



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered

February 25, 2025

Licensee  
Brookdale Mankato  
100 Teton Lane  
Mankato, MN 56001

RE: Project Number(s) SL30560016

Dear Licensee:

On January 22, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the November 7, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Kelly Thorson'.

Kelly Thorson, Supervisor  
State Evaluation Team  
Email: Kelly.Thorson@state.mn.us  
Telephone: 320-223-7336 Fax: 1-866-890-9290

HHH



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered

December 13, 2024

Licensee  
Brookdale Mankato  
100 Teton Lane  
Mankato, MN 56001

RE: Project Number(s) SL30560016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on November 7, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

#### **STATE CORRECTION ORDERS**

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

#### **IMPOSITION OF FINES**

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

Level 1: no fines or enforcement.

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

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

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

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

**St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - \$3,000.00**

**St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - \$3,000.00**

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$6,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

#### **DOCUMENTATION OF ACTION TO COMPLY**

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

The correction order documentation should include the following:

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

#### **CORRECTION ORDER RECONSIDERATION PROCESS**

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

To submit a reconsideration request, please visit:

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

#### **REQUESTING A HEARING**

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

To submit a hearing request, please visit:

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you

Brookdale Mankato

December 13, 2024

Page 3

may request a reconsideration or a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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

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

If you have any questions, please contact me.

Sincerely,

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

Jodi Johnson, Supervisor

State Evaluation Team

Email: [Jodi.Johnson@state.mn.us](mailto:Jodi.Johnson@state.mn.us)

Telephone: 507-344-2730 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>30560</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/07/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BROOKDALE MANKATO</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>100 TETON LANE MANKATO, MN 56001</b>
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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
0 000	<p><b>Initial Comments</b></p> <p><b>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)</b></p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.</p> <p>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.</p> <p><b>INITIAL COMMENTS:</b></p> <p>SL30560016-0</p> <p>On November 4, 2024, through November 7, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 17 residents; 16 receiving services under the Assisted Living Facility license.</p> <p>1290: An immediate correction order was issued on November 7, 2024, at a level 3/Widespread. Actions were taken on November 7, 2024, to mitigate the risk, but the citation remains at a level 3/Widespread.</p> <p>2310: An immediate correction order was issued on November 6, 2024, at a level 3/Widespread. Actions were taken on November 6, 2024, to mitigate the risk, but the citation remains at a level 3/Widespread.</p>	0 000	<p>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.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>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.</p>	

Minnesota Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

Minnesota Department of Health

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0 480	Continued From page 1	0 480		
0 480 SS=F	<p><b>144G.41 Subd 1 (13) (i) (B) Minimum requirements</b></p> <p>(13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).</p> <p>The findings include:</p> <p>Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated November 5, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.</p> <p>TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.</p>	0 480		
0 510 SS=D	<b>144G.41 Subd. 3 Infection control program</b>	0 510		

Minnesota Department of Health

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0 510	<p>Continued From page 2</p> <p>(a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control.</p> <p>(b) The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities.</p> <p>(c) The facility must maintain written evidence of compliance with this subdivision.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complies with accepted health care, medical and nursing standards for infection control related to glove use by one of one unlicensed personnel (ULP-C) observed during medication administration.</p> <p>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).</p> <p>The findings include:</p> <p>R1's Personal Service Plan dated September 25, 2024, indicated the resident received services including medication administration.</p>	0 510		

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0 510	<p>Continued From page 3</p> <p>On November 5, 2024, at 11:47 a.m., ULP-C was observed setting up R1's medications for administration. R1's scheduled medications included CholestOff Complete (a dietary supplement used to lower cholesterol) 450 milligrams (mg) by mouth in the morning and glucosamine-chondroitin (supplements that may help with arthritis pain) 500-400 mg one tablet by mouth twice a day; each medication was supplied over-the-counter in a medication bottle. While dishing up the medications, ULP-C was observed to open each medication bottle, and with bare hands, retrieve one tablet from each bottle with her fingers. When asked if that was how she was trained to administer medication from a bottle, ULP-C stated, "not really." ULP-C further stated they didn't have too many medications that were in bottles.</p> <p>On November 5, 2024, at 12:24 p.m., executive director/clinical nurse supervisor (ED/CNS)-A stated when administering medications from a bottle, staff were expected to pour the medication into the cap of the bottle then pour into the medication cup. If staff needed to touch the medication, they were to apply gloves and never touch the medication with bare hands.</p> <p>The licensee's Medication &amp; Treatment - General Guidelines for Medication Administration/Assistance policy revised July 2024, indicated: 1. Trained or licensed associates administering or assisting with medications should:     13. Gloves should be worn when administering eye/ear drops, injectable medications (IM/SC/Insulin, etc.), or any other medication in contact with bodily fluids, etc. Gloves should also be worn when cutting tablets</p>	0 510		

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0 510	Continued From page 4  in half or touching them for other reasons.  No further information provided.  TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 780 SS=E	<p>144G.45 Subd. 2 (a) (1) Fire protection and physical environment</p> <p>(a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:</p> <p>(1) for dwellings or sleeping units, as defined in the State Fire Code:</p> <ul style="list-style-type: none"> <li>(i) provide smoke alarms in each room used for sleeping purposes;</li> <li>(ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms;</li> <li>(iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics;</li> <li>(iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and</li> <li>(v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;</li> </ul> <p>This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee</p>	0 780		

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0 780	<p>Continued From page 5</p> <p>failed to maintain smoke alarms, fire separation, and provide approved ashtrays. This deficient condition had the ability to affect all staff and residents.</p> <p>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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).</p> <p>The findings include:</p> <p>During facility tour on November 6, 2024, from 9:35 a.m., through 10:50 a.m. with maintenance manager (MM)-F, the surveyor observed the following:</p> <p>The water heater PVC vents in the mechanical room went through the ceiling drywall into the attic area. There was red fire caulking present on the PVC vents and the drywall, but the caulking did not make a complete seal from the drywall to the PVC vents. MM-F stated that they just had the air ducts cleaned by a contractor and thought that the contractor had moved the PVC vents and caused the fire caulk to become separated from the ceiling. Fire caulking must be maintained to create a complete seal to prevent fire from spreading into adjoining building areas.</p> <p>Resident room 19 had a smoke alarm mounted on the ceiling with the battery compartment open and the battery was removed. MM-F asked the resident if the alarm was beeping, and they removed the battery. The resident did not respond, and MM-F stated they would install a</p>	0 780		

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0 780	<p>Continued From page 6</p> <p>new battery.</p> <p>There was a metal ashtray in the rear of the building and MM-F stated that was the residents designated smoking area. A resident was observed smoking on the front sidewalk and there was a plastic container on the sidewalk with cigarette butts in it. The surveyor explained that the plastic container was not an approved, non-combustible ashtray. MM-F stated they would install another ashtray in the front of the building.</p> <p>During the tour MM-F verified the above findings and stated they understood the requirements.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days.</p>	0 780		
0 970 SS=C	<p>144G.50 Subd. 5 Waivers of liability prohibited</p> <p>The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident. This had the potential to affect all residents.</p>	0 970		

Minnesota Department of Health

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0 970	<p>Continued From page 7</p> <p>This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>The licensee's assisted living Residency Agreement contract revised December 2023, included a clause that indicated the resident would waive the licensee's liability for health, safety, or personal property of a resident. -Page 13, section VI. C. of the contract indicated: "INDEMNIFICATION. you, and /or your Legal Representative agree to indemnify and hold us and our affiliated entities harmless from any losses, liabilities, damages, and other expenses brought against us and/or an affiliated entity or individual arising, directly or indirectly, from your alleged negligent acts and/or omissions and/or the alleged negligent acts and/or omissions of a third-party acting on your behalf. Such acts or omissions may include, but not be limited to, your failure to safely utilize personal property (e.g. electric scooter), your failure to follow prescribed care and services, your third-party's failure to provide proper care and services to you or causing harm/injury to another party, you or your third-party's improper use of Community property, or your breach of the Agreement."</p> <p>On November 5, 2024, at 12:24 p.m. executive director/clinical nurse supervisor (ED/CNS)-A reviewed the licensee's current contract and stated it included the above content. Director of clinical service (DOCS)-E stated this would be the</p>	0 970		

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0 970	Continued From page 8  contract utilized for all residents at the facility.  No further information was provided.  TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01060 SS=F	144G.52 Subd. 9 Emergency relocation  (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and	01060		

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01060	<p>Continued From page 9</p> <p>designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation when the residents had not returned to the facility within four days for one of one resident (R1).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).</p> <p>The findings include:</p> <p>R1's diagnoses included morbid (severe) obesity, chronic pain, and osteoarthritis.</p> <p>R1's Personal Service Plan dated September 25, 2024, indicated R1 received services including</p>	01060		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>30560</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/07/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BROOKDALE MANKATO</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>100 TETON LANE MANKATO, MN 56001</b>
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01060	<p>Continued From page 10</p> <p>medication administration, treatments, housekeeping, laundry, and assistance with bathing, dressing, grooming, transfers, bed mobility, and ambulation.</p> <p>R1's After Visit Summary dated June 19, 2024, indicated R1 had been hospitalized on June 13, 2024, and discharged on June 19, 2024.</p> <p>R1's record lacked a written notice that contained, at a minimum:</p> <ul style="list-style-type: none"> <li>- the reason for the relocation;</li> <li>- the name and contact information for the location to which the resident has been relocated and any new service provider;</li> <li>- contact information for the Office of Ombudsman for Long-Term Care;</li> <li>- if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known;</li> <li>- a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal.</li> </ul> <p>In addition, R1's record lacked evidence of notification to OOLTC when they were hospitalized more than four days.</p> <p>On November 5, 2024, at 10:15 a.m. executive director/clinical nurse supervisor (ED/CNS)-A stated the licensee did not provide an emergency transfer notice to resident, legal representative, and designated representative when residents were hospitalized, nor were they notifying the ombudsman when the relocation exceeded four days. ED/CNS-A stated being unaware of the requirement.</p>	01060		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>30560</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/07/2024</b>
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01060	<p>Continued From page 11</p> <p>The licensee's Admission/Discharge Policy revised August 2021, indicated:</p> <p>12. Emergency Relocation.</p> <p>b. In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum:</p> <ul style="list-style-type: none"> <li>i. The reason for the relocation;</li> <li>ii. The name and contact information for the location to which the resident has been relocated and any new service provider;</li> <li>iii. Contact information for the Office of Ombudsman for Long-Term Care;</li> <li>iv. If known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and</li> <li>v. A statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal.</li> </ul> <p>c. The notice must be delivered as soon as practicable to:</p> <ul style="list-style-type: none"> <li>i. The resident, legal representative, and designated representative;</li> <li>ii. For residents who receive home and community-based waiver services, the resident's case manager; and</li> <li>iii. The Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days.</li> </ul> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-One (21) days</p>	01060		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>30560</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>11/07/2024</b>
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01290 SS=I	<p><b>144G.60 Subdivision 1 Background studies required</b></p> <p>(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.</p> <p>(b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12.</p> <p>(c) Termination of an employee 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.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was current and eligible on NETStudy 2.0 (web-based system for submitting background study requests to the Department of Human Services (DHS)) with the assisted living license for one of three employees (unlicensed personnel (ULP)-G). This had the potential to affect all residents residing in the facility. This resulted in an immediate correction order issued on November 7, 2024.</p> <p>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large</p>	01290		

Minnesota Department of Health

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01290	<p>Continued From page 13</p> <p>portion or all of the residents).</p> <p>The findings include:</p> <p>ULP-G was hired on September 15, 2021, to provide direct care services for the licensee's residents.</p> <p>On November 7, 2024, at 11:55 a.m. executive director/clinical nurse supervisor (ED/CNS)-A provided the NETStudy 2.0 employee roster for health facility identification number (HFID) 30560 at the surveyor's request. ULP-G's background study dated September 10, 2021, was affiliated to HFID 30560, but indicated "Eligible - COVID-19 Study - Expired" with an expiration date of December 31, 2022, on the NETStudy 2.0 roster page. ED/CNS-A was not aware ULP-B's background study was COVID-19 NETStudy 2.0 expired and stated all employees were required to have a cleared background check before performing duties at the facility. ED/CNS-A further stated ULP-G worked independently providing direct care to the residents.</p> <p>The Minnesota Department of Human Services website updated July 31, 2024, indicated the following: Emergency studies completed during the COVID-19 pandemic were no longer valid and modifications ended January 1, 2023. Individuals who only had an emergency study must have a fully compliant, fingerprint-based background study. Roster maintenance - Individuals with a completed emergency study will remain on the entity's roster unless the entity removes the individual. Entities should remove individuals with emergency studies that are no longer affiliated;</p>	01290		

Minnesota Department of Health

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01290	<p>Continued From page 14</p> <ul style="list-style-type: none"> <li>- All entities are responsible for maintaining their rosters regularly and removing study subjects from their roster when they are no longer affiliated; and</li> <li>- Entities are responsible for identifying who needs to submit a new background study. For help identifying which study subjects still have an emergency study and need a fully compliant study, entities should refer to the instructional guide, "Identifying Emergency Studies" in the help section of NETStudy 2.0.</li> </ul> <p>The licensee's background studies policy was requested but not received.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Immediate</p> <p>On November 7, 2024, the facility implemented corrective actions to address this issue. The scope and severity remains at I.</p>	01290		
01620 SS=D	<p>144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring</p> <p>(c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment.</p> <p>(d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of</p>	01620		

Minnesota Department of Health

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01620	<p>Continued From page 15</p> <p>services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment not to exceed 90 calendar days from the last assessment, for one of two residents (R2).</p> <p>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).</p> <p>The findings include:</p> <p>R2's diagnoses included bipolar disorder, hypertension, hyperlipidemia (high cholesterol), gastro-esophageal reflux disease (GERD - heartburn), asthma, and constipation.</p> <p>R2's Personal Service Plan dated August 28, 2024, indicated R2 received services including medication administration, housekeeping,</p>	01620		

Minnesota Department of Health

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01620	<p>Continued From page 16</p> <p>laundry, and assistance with bathing, dressing, toileting, behavior management, and application of left knee support sleeve.</p> <p>R2's last three assessments were requested. Assessments dated March 27, 2024, July 16, 2024, and October 14, 2024, were provided. 111 days had passed between the March and July assessments (21 days late), and 94 days had passed between the July and October assessments (4 days late).</p> <p>On November 7, 2024, at 9:46 a.m., executive director/clinical nurse supervisor (ED/CNS)-A stated R2's last two 90-day assessments had not been completed within 90 days as required.</p> <p>The licensee's Evaluation Process Policy revised August 2021, indicated:</p> <ol style="list-style-type: none"> <li>1. A Registered Nurse should complete a Personal Service Assessment/               <ol style="list-style-type: none"> <li>a. Prior to signing a contract or date of move-in, whichever is earliest.</li> <li>b. No more than 14 days after move-in;</li> <li>c. At least every 89 days or;</li> <li>d. As soon as possible after a change of condition that results in altered care needs.</li> </ol> </li> </ol> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-One (21) days</p>	01620		
01650 SS=F	<p>144G.70 Subd. 4 (f) Service plan, implementation and revisions to</p> <p>(f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each</p>	01650		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>30560</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/07/2024</b>
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01650	<p>Continued From page 17</p> <p>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 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.</p> <p>This MN Requirement is not met as evidenced by:                      Based on observation, interview, and record review, the licensee failed to ensure two of two residents' (R1, R2) service plans included all the required content.</p> <p>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</p>	01650		

Minnesota Department of Health

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01650	<p>Continued From page 18</p> <p>failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p><b>R1</b> R1 began receiving assisted living services on April 29, 2024.</p> <p>R1's Personal Service Plan dated September 25, 2024, indicated R1 received services including medication administration, treatments, housekeeping, laundry, and assistance with bathing, dressing, grooming, transfers, bed mobility, and ambulation.</p> <p>On November 5, 2024, at 11:47 a.m., unlicensed personnel (ULP)-C was observed administering medications to R1.</p> <p><b>R2</b> R2 began receiving assisted living services on August 1, 2021.</p> <p>R2's Personal Service Plan dated August 28, 2024, indicated R2 received services including medication administration, housekeeping, laundry, and assistance with bathing, dressing, toileting, behavior management, and application of left knee support sleeve.</p> <p>On November 6, 2024, at 1:17 p.m., ULP-C was observed administering eye drops to R2.</p> <p>R1 and R2's Personal Service Plan lacked the following: - the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; - the schedule and methods of monitoring</p>	01650		

Minnesota Department of Health

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01650	<p>Continued From page 19</p> <p>assessments of the resident; the schedule and methods of monitoring staff providing services; and - a contingency plan that includes: - action to be taken if the scheduled service cannot be provided; - information and a method to contact the facility; - 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 authority to sign for the resident in an emergency; and - the circumstances in which emergency medical services are not go be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters.</p> <p>On November 6, 2024, at 8:25 a.m., executive director/clinical nurse supervisor (ED/CNS)-A stated the above required content was not included in the personal service plan for any residents.</p> <p>The licensee's Service Plan Process Policy revised March 2020, did not indicate need for the missing required content.</p> <p>No further information was provided.</p> <p><b>TIME PERIOD FOR CORRECTION:</b> Twenty-One (21) days.</p>	01650		
01730 SS=E	144G.71 Subd. 5 Individualized medication management plan	01730		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>30560</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/07/2024</b>
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01730	<p>Continued From page 20</p> <p>(a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following:</p> <ol style="list-style-type: none"> <li>(1) a statement describing the medication management services that will be provided;</li> <li>(2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions;</li> <li>(3) documentation of specific resident instructions relating to the administration of medications;</li> <li>(4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis;</li> <li>(5) identification of medication management tasks that may be delegated to unlicensed personnel;</li> <li>(6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and</li> <li>(7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions.</li> </ol> <p>(b) The medication management record must be current and updated when there are any changes.</p> <p>(c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing</p>	01730		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>30560</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/07/2024</b>
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01730	<p>Continued From page 21</p> <p>medication management.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a current individualized medication management plan with the required content for two of two residents (R1, R2).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).</p> <p>The findings include:</p> <p>During the entrance conference on November 4, 2024, at 10:40 a.m., executive director/clinical nurse supervisor (ED/CNS)-A stated the licensee provided medication management services to the residents at the facility.</p> <p>R1 R1's diagnoses included diabetes mellitus, major depression, hypertension (high blood pressure), hypercholesterolemia (high cholesterol), hypothyroidism (underactive thyroid), chronic pain, osteoarthritis, iron deficiency anemia, lymphedema, and pulmonary embolism.</p> <p>R1's Personal Service Plan dated September 25, 2024, indicated R1 received services including medication administration.</p>	01730		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>30560</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/07/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BROOKDALE MANKATO</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>100 TETON LANE MANKATO, MN 56001</b>
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01730	<p>Continued From page 22</p> <p>R1's prescriber orders dated August 21, 2024, included two for diabetes, one blood thinner, one potassium supplement, two for depression, one mood stabilizer, one for anxiety, one iron supplement, one to lower cholesterol, one diuretic, one for thyroid, two for pain, and three supplements.</p> <p>On November 5, 2024, at 11:47 a.m., unlicensed personnel (ULP)-C was observed administering medications to R1.</p> <p>R2 R2's diagnoses included bipolar disorder, hypertension, hyperlipidemia (high cholesterol), gastro-esophageal reflux disease (GERD - heartburn), asthma, and constipation.</p> <p>R2's Personal Service Plan dated August 28, 2024, indicated R2 received services including medication administration.</p> <p>R2's prescriber orders dated September 18, 2024, included four for hypertension, four for bipolar disorder, one for hyperlipemia, one for GERD, one for diabetes, three supplements, one for constipation, and one for pain.</p> <p>On November 6, 2024, at 1:17 p.m., ULP-C was observed administering eye drops to R2.</p> <p>R1 and R2's individual medication management plans lacked: - procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services</p> <p>On November 7, 2024, at 9:46 a.m., ED/CNS-A</p>	01730		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>30560</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/07/2024</b>
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01730	<p>Continued From page 23</p> <p>reviewed R1 and R2's individualized medication management plans and stated they did not include the above required content.</p> <p>A policy on individualized medication management plans was requested but not received.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	01730		
01760 SS=D	<p>144G.71 Subd. 8 Documentation of administration of medication</p> <p>Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered as ordered for 1 of 4 residents (R5).</p> <p>This practice resulted in a level two violation (a</p>	01760		

Minnesota Department of Health

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01760	<p>Continued From page 24</p> <p>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).</p> <p>The findings include:</p> <p>R5's diagnoses included glaucoma and foot pain.</p> <p>R5's Personal Service Plan dated August 28, 2024, indicated R5's services included medication administration.</p> <p>R5's provider note dated October 16, 2024, included an order for Muro 128 5% ophthalmic ointment. Instill one application in right eye three times a day for corneal pressure. The note further included a new order for diclofenac sodium 1% external gel. Apply to right food twice a day, may apply up to 0.75 grams per application.</p> <p>On November 5, 2024, at 8:35 a.m., unlicensed personnel (ULP)-C was observed setting up and administering medications (including Muro ointment and diclofenac sodium gel) to R5. While ULP-C set up each medication for R5, the surveyor observed each medication prescription label. R5's Muro 128 5% ophthalmic ointment label indicated the medication was to be administered into the crescent of both lower lids at bedtime. ULP-C stated the label was incorrect and the order was three times a day. When administering the Muro ointment to R5, ULP-C applied the ointment into the crescent of both lower eyelids. R5 questioned ULP-C stating,</p>	01760		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>30560</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>11/07/2024</b>
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01760	<p>Continued From page 25</p> <p>"Both lids?"; ULP-C stated that was what the order indicated. When applying the diclofenac sodium 1% external gel, ULP-C squeezed approximately a nickel size amount onto her gloved hand and applied to R5's right foot. Immediately following the observation, the surveyor asked ULP-C how she measures the amount of diclofenac sodium gel when administering to R5. ULP-C stated she had not been trained on how to measure the dose of a prescription gel.</p> <p>On November 5, 2024, at 12:24 p.m., executive director/clinical nurse supervisor (ED/CNS)-A reviewed R5's Muro eye ointment provider order and stated it should be applied to the right eye only three times daily. ED/CNS-A observed R5's Muro eye ointment in the medication cart with ULP-C. ULP-C stated the label was incorrect and stated the order in the electronic medication administration record (eMAR) indicated the ointment should be applied to both eyes. ULP-C brought up R5's Muro eye ointment order in the eMAR. The eMAR reflected the current order to be applied three times a day to the right eye. Below the order was also verbiage that contradicted this, indicating to apply to both eyes three times a day. ED/CNS-A stated this was confusing and contacted the pharmacy. ED/CNS-A stated R5's previous Muro eye ointment order transcription remained on the eMAR below the current order. ED/CNS-A stated not knowing this was occurring as when the MAR was printed out the previous order transcription was not included. ED/CNS-A further stated she had directed the pharmacy to remove the previous order from the eMAR to prevent further errors.</p> <p>On November 6, 2024, at 9:51 a.m., ED/CNS-A</p>	01760		

Minnesota Department of Health

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01760	<p>Continued From page 26</p> <p>stated ULPs are trained to measure prescription gel with the measuring tool provided with the medication, and are expected to utilize it.</p> <p>The licensee's Medication &amp; Treatment - General Guidelines for Medication Administration/Assistance policy revised July 2024, indicated:</p> <p>1. Trained or licensed associates administering or assisting with medications should:</p> <p style="padding-left: 20px;">a. Follow the "7 Rights of Medication Administration: right medication, right dose, right time, right route, right resident, right documentation, and right to refuse.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days.</p>	01760		
01890 SS=E	<p><b>144G.71 Subd. 20 Prescription drugs</b></p> <p>A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure time sensitive medications had an opened date for one of one resident (R4) with insulin and failed to ensure accurate labeling for two of four residents (R5, R1) during medication administration.</p>	01890		

Minnesota Department of Health

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01890	<p>Continued From page 27</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).</p> <p>The findings include:</p> <p><b>R4</b> R4's diagnoses included type II diabetes mellitus with hyperglycemia (high blood sugar).</p> <p>R4's Personal Service Plan dated October 2, 2024, indicated R4 received assistance with medication administration.</p> <p>R4's provider orders dated October 16, 2024, included Novolog FlexPen (an injectable medication for diabetes) 100 unit/ml (milliliter) subcutaneous solution pen-injector. Inject TID (three times a day) with meals using SS (sliding scale) = 140-179= 2 units, 180-219 = 4 units, 220-259 = 6 units, 260-299 = 8 units, 300-339 = 10 units, 240-379 = 12 units and 380-399 = 13 units.</p> <p>On November 5, 2024, at 7:25 a.m., the surveyor observed unlicensed personnel (ULP)-C obtain R4's blood sugar and administer R4's Novolog FlexPen insulin. The insulin pen did not include a date when opened. When interviewed immediately following the observation, ULP-C stated she did not date insulin pens when opening a new one.</p>	01890		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>30560</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/07/2024</b>
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01890	<p>Continued From page 28</p> <p>On November 5, 2024, at 12:24 p.m., executive director/clinical nurse supervisor (ED/CNS)-A stated the expectation was to date insulin pens when opened, and further stated staff had been trained to do this.</p> <p>The licensee's How To: Use an Insulin Pen form revised September 2024, indicated: Packaging and Storing: 1. Pens must be stored ad refrigerated in their original box until time of use. A pharmacy label must be visibly on the pen body (not the cap) with the resident's name and space for date of use to be marked. 2. Pens in use will be dated upon opening and stored at room temperature (59 F (Fahrenheit) to 86 F) in the medication cart until the time specified by the manufacturer.</p> <p>The Novolog FlexPen Instructions for Use dated April 2015, indicated: The Novolog FlexPen you are using should be thrown away after 28 days, even if it still has insulin left in it.</p> <p>R5 R5's diagnoses included glaucoma and foot pain.</p> <p>R5's Personal Service Plan dated August 28, 2024, indicated services included medication administration.</p> <p>R5's provider note dated October 16, 2024, included an order for Muro 128 5% ophthalmic ointment. Instill one application in right eye three times a day for corneal pressure.</p> <p>On November 5, 2024, at 8:35 a.m., ULP-C was observed administering medication to R5 including Muro 128 5% ophthalmic ointment. The prescription label on the ointment indicated to</p>	01890		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>30560</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/07/2024</b>
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01890	<p>Continued From page 29</p> <p>instill into crescent of both lower lids every bedtime. The prescription label did not match the current provider order.</p> <p>On November 5, 2024, at 12:24 p.m., ED/CNS-A observed R5's Muro eye ointment prescription label and compared with R5's current provider orders. ED/CNS-A stated there was a discrepancy, and the nurse should have been notified.</p> <p>R1 R1's diagnoses included constipation.</p> <p>R1's Personal Service Plan dated September 25, 2024, indicated services included medication administration.</p> <p>R1's provider note dated August 21, 2024, included an order for Senexon-S 8.6-50 mg (milligrams) oral tablet. Give one tablet by mouth twice daily for constipation. The prescription label did not match the current physician order.</p> <p>On November 5, 2024, at 11:47 a.m., ULP-C was observed administering medication to R1 including Senexon-S 8.6-50 mg oral tablet. The prescription label indicated to administer twice daily as needed for constipation. The prescription label did not match the current provider order.</p> <p>On November 5, 2024, at 12:24 p.m., ED/CNS-A observed R1's Senexon-S prescription label and compared with R1's current provider orders. ED/CNS-A stated there was a discrepancy and the nurse should have been notified.</p> <p>The licensee's Medication &amp; Treatment - General Guidelines for Medication Administration/Assistance policy revised July</p>	01890		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>30560</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/07/2024</b>
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01890	Continued From page 30  2024, indicated: 1. Trained or licensed associates administering or assisting with medications should: a. Follow the "7 Rights of Medication Administration: right medication, right dose, right time, right route, right resident, right documentation, and right to refuse.  No further information was provided.  TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
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, date of disposition, and names of staff and other individuals involved in the disposition.  This MN Requirement is not met as evidenced by:	01910		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>30560</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/07/2024</b>
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01910	<p>Continued From page 31</p> <p>Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medication including the medication's prescription number as applicable, for one of one discharged resident (R3).</p> <p>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).</p> <p>The findings include:</p> <p>R3's Discharge Summary dated October 23, 2024, indicated R3 was admitted to the facility on July 12, 2023, and discharged on October 23, 2024.</p> <p>R3's Service Plan dated August 28, 2024, included medication administration.</p> <p>R3's MN-Medication Release When Resident is Absent from the Community form dated October 23, 2024, included medications that had been sent with R3.</p> <p>The document identified the medication name, strength, quantity, and signature of the nurse. The document did not include the prescription number for any of the medications including: lorazepam (for anxiety), ipratropium albuterol (nebulizer for shortness of breath), guaifenesin (for cough), loratadine (allergies), ibuprofen (pain), gabapentin (anticonvulsant), sertraline</p>	01910		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>30560</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>11/07/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BROOKDALE MANKATO</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>100 TETON LANE MANKATO, MN 56001</b>
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01910	<p>Continued From page 32</p> <p>(antidepressant), acetaminophen (pain), Trelegy inhaler, Anoro inhaler, and amlodipine (high blood pressure).</p> <p>On November 4, 2024, at 3:30 p.m., executive director/clinical nurse supervisor (ED/CNS)-A provided the above form to the surveyor. ED/CNS-A reviewed the form and stated it did not include the prescription number for R3's listed medications.</p> <p>The licensee's Medications &amp; Treatments - Unused Medication Disposal/Return to Resident /Legally Responsible Party or Pharmacy policy revised October 2022, indicated:</p> <p>1. Returning Non-Controlled Medications to Resident/Legally Responsible Party. When returning medications to the resident/legally responsible party, the nurse, Executive Director or designee should:</p> <p>b) Complete the applicable information on a Medication Disposal - Return to Pharmacy or Resident/Legally Responsible Party form when the medications are released to the resident/legally responsible party.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	01910		
01940 SS=D	<p>144G.72 Subd. 3 Individualized treatment or therapy management</p> <p>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</p>	01940		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>30560</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/07/2024</b>
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01940	<p>Continued From page 33</p> <p>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:</p> <p>(1) a statement of the type of services that will be provided;</p> <p>(2) documentation of specific resident instructions relating to the treatments or therapy administration;</p> <p>(3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel;</p> <p>(4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and</p> <p>(5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of one resident (R2).</p> <p>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</p>	01940		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>30560</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/07/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BROOKDALE MANKATO</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>100 TETON LANE MANKATO, MN 56001</b>
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01940	<p>Continued From page 34</p> <p>a limited number of staff are involved or the situation has occurred only occasionally).</p> <p>The findings include:</p> <p>During the entrance conference on November 4, 2024, at 10:40 a.m., executive director/clinical nurse supervisor (ED/CNS)-A stated the licensee provided treatment and therapy services to the residents at the facility.</p> <p>R2's Personal Service Plan dated August 28, 2024, indicated R2 received services including assistance with application of left knee support.</p> <p>On November 6, 2024, at 1:17 p.m., R2 stated having an elastic brace for her left knee that she only wore when up walking. R2 stated staff helped her put it on as it was too difficult for her to do independently.</p> <p>R2's Treatment or Therapy Management Service Plan dated October 18, 2024, did not include the left knee support.</p> <p>R2's record lacked a treatment management plan that was individualized to include procedures for notifying a registered nurse (RN) when a problem arose with specific criteria on when to notify the RN.</p> <p>On November 7, 2024, at 9:46 a.m., ED/CNS-A reviewed R2's record and stated it did not include when to contact the RN related to the left knee support.</p> <p>The licensee's Treatment or Therapy Management Services policy revised February 2023, indicated: Treatment or Therapy</p>	01940		

Minnesota Department of Health

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01940	<p>Continued From page 35</p> <p>Management Service Plan should be completed by a Registered Nurse (RN), face to face upon admission/move-in, every 90-days and with any changes. The individualized treatment or therapy management plan is to be included in the Service plan with client specific instructions.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	01940		
02310 SS=I	<p>144G.91 Subd. 4 (a) Appropriate care and services</p> <p>(a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure care and services were provided according to acceptable health care, medical or nursing standards for the licensee's one resident (R1) with a bed rail. This resulted in an immediate correction order on November 6, 2024.</p> <p>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large</p>	02310		

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER  <b>BROOKDALE MANKATO</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>100 TETON LANE MANKATO, MN 56001</b>
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02310	<p>Continued From page 36</p> <p>portion or all of the residents).</p> <p>The findings include:</p> <p>On November 5, 2024, at 11:47 a.m., unlicensed personnel (ULP)-C was observed administering medications to R1 in R1's room. R1 was observed lying in bed; there were bilateral Halo assist bars attached to the head of the bed.</p> <p>R1's diagnoses included morbid (severe) obesity, chronic pain, and osteoarthritis.</p> <p>R1's Personal Service Plan dated April 1, 2024, indicated R1 received services including medication administration, treatments, housekeeping, laundry, and assistance with bathing, dressing, grooming, transfers, bed mobility, and ambulation.</p> <p>R1's record lacked:</p> <ul style="list-style-type: none"> <li>- an assessment for bed rail use; and</li> <li>- documentation R1's bed rail was checked for recalls with the Consumer Product Safety Commission (CPSC).</li> </ul> <p>On November 6, 2024, at 11:16 a.m., executive director/clinical nurse supervisor (ED/CNS)-A stated a Negotiated Risk Agreement form had been reviewed and signed by R1. ED/CNS-A stated the maintenance manager (MM)-F installed the rails per the manufacturer's instructions, and she (ED/CNS)-A ensured the rails were stable and observed R1's use of the rails; however, they did not have documented evidence to support this.</p> <p>The Food and Drug Administration's (FDA) A Guide to Bed Safety Bed Rails in Hospitals Nursing Homes and Home Health Care dated</p>	02310		

Minnesota Department of Health

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02310	<p>Continued From page 37</p> <p>June 21, 2006, indicated the following information: "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe."</p> <p>The Minnesota Department of Health (MDH) website, Assisted Living Resources &amp; Frequently-Asked Questions (FAQs) last updated April 3, 2024, indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to:</p> <ul style="list-style-type: none"> <li>- Purpose and intention of the bed rail;</li> <li>- Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail;</li> <li>- The resident's bed rail use/need assessment;</li> <li>- Risk vs. benefits discussion (individualized to each resident's risks);</li> <li>- The resident's preferences;</li> <li>- Installation and use according to manufacturer's guidelines;</li> <li>- Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and</li> </ul>	02310		

Minnesota Department of Health

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02310	<p>Continued From page 38</p> <p>- Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements".</p> <p>The MDH website also indicated for consumer bed rails, the licensee should refer to the CPSC for the most up-to-date information related to portable bed rail recall information.</p> <p>The licensee's Bedside Mobility Aids policy revised March 2020, indicated: In promoting a safe and restraint free environment, while at the same time acknowledging individual resident's mobility needs, [licensee name] allows the use of certain bedside mobility aids with an appropriate physician/licensed prescriber order and after review by our District Director of Operations (DDO)/Regional Vice President (RVP)/Designee and District or Regional Nurse/Designee. The DDO/RVP and District or Regional Nurse/designee should be notified prior to the initiation of any bedside mobility aid. Bedside mobility aids should not be used as a restrictive device.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Immediate</p> <p>On November 6, 2024, the facility implemented corrective actions to address this issue. The scope and severity remains at I.</p>	02310		



Type: Full  
Date: 11/05/24  
Time: 12:26:49  
Report: 1028241030

## Food and Beverage Establishment Inspection Report

Page 1

### Location:

Brookdale Mankato  
100 Teton Lane  
Mankato, MN56001  
Blue Earth County, 07

### Establishment Info:

ID #: 0010848  
Risk: Medium  
Announced Inspection: No

### License Categories:

Expires on: / /

### Operator:

Brookdale Senior Living Commun

Phone #: 4149185515

ID #: 11571

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

The following orders were issued during this inspection.

### 6-300 Physical Facility Numbers and Capacities

#### 6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

Provide a handwashing sign in the employee bathroom instructing employees to wash their hands before returning to work.

Comply By: 11/06/24

### Surface and Equipment Sanitizers

Hot Water: = at 192 Degrees Fahrenheit

Location: Dish Machine - Rinse

Violation Issued: No

### Food and Equipment Temperatures

Process/Item: Cold Holding

Temperature: 38 Degrees Fahrenheit - Location: Sliced Tomatoes

Violation Issued: No

Process/Item: Upright Freezer

Temperature: -7 Degrees Fahrenheit - Location: Arctic Air - Ambient

Violation Issued: No

Process/Item: Upright Freezer

Temperature: -11 Degrees Fahrenheit - Location: True - Ambient

Violation Issued: No

Type: Full  
Date: 11/05/24  
Time: 12:26:49  
Report: 1028241030  
Brookdale Mankato

# Food and Beverage Establishment Inspection Report

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Process/Item: Cold Holding  
Temperature: 39 Degrees Fahrenheit - Location: Chicken Rice Soup  
Violation Issued: No

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

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

I acknowledge receipt of the Minnesota Dept. of Health inspection report number 1028241030 of 11/05/24.

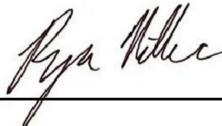
Certified Food Protection Manager Kyle Willaert

Certification Number: FM124298 Expires: 05/21/27

**Inspection report reviewed with person in charge and emailed.**

Signed: \_\_\_\_\_

Kyle Willaert  
Cook

Signed:  \_\_\_\_\_

Ryan Miller  
Environmental Health Specialist  
MDH - Mankato  
507-995-7672  
Ryan.Miller@state.mn.us