Electronically Delivered

October 21, 2025

Licensee
Mankato Lodge Senior Living
1360 Adams Street
Mankato, MN 56001

RE: Project Number(s) SL30723016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 18, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in 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 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00
St - 0 - 1370 - 144g.61 Subd. 2 (a) - Training And Evaluation Of Unlicensed Personn - $1,000.00
St - 0 - 1760 - 144g.71 Subd. 8 - Documentation Of Administration Of Medication - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $4,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

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

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30723	A. BUILDING: _____ B. WING _____	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANKATO LODGE SENIOR LIVING	1360 ADAMS STREET MANKATO, MN 56001

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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: SL30723016-0 On September 15, 2025, through September 18, 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 65 residents; 25 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.	
0 470 SS=C	144G.41 Subdivision 1 Minimum requirements	0 470		

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0 470	Continued From page 1 (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 ensure the staffing schedule was posted as required, potentially affecting the licensee's current residents and any visitors. This practice resulted in a level one violation (a	0 470		

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0 470	Continued From page 2 violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee lacked a daily staffing schedule developed by the clinical nurse supervisor per Assisted Living Facilities: Minnesota Rules Chapter 4659.0180 Subp. 4. to: - include direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked; - identify the direct-care staff member's resident assignments or work location; and - be posted after redacting direct-care staff member's resident assignments, at the beginning of each work shift in a central location in each building. On September 15, 2025, at 10:00 a.m. upon entrance into the facility, the surveyor observed the licensee's posted documents. There was no evidence of a staff schedule posting. During the facility tour on September 15, 2025, at 12:12 p.m., assisted living director in residence (ALDIR)-A stated the daily staff schedule used to be completed and posted by the nurse on the bulletin board near the elevator. ALDIR-A observed the bulletin board with the surveyor and stated there was no staff schedule posted for residents and visitors. The licensee's Staffing Plan and Postings policy	0 470		

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0 470	Continued From page 3 dated August 24, 2021, indicated: 2. Daily staffing schedule. a. The clinical nurse supervisor must develop a 24-hour daily staffing schedule. The schedule must: i. include direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked; and ii. identify the direct-care staff member's resident assignments or work location. b. The daily work schedule in item A must be posted, after redacting direct-care staff member's resident assignments, at the beginning of each work shift in a central location in each building of a community or campus, accessible to staff, residents, volunteers, and the public. The community shall not disclose any information that is protected by law from public disclosure. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 470		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the	0 480		

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0 480	Continued From page 4 CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door.	0 480		

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0 480	Continued From page 5 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated September 16, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:	0 775		

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0 775	Continued From page 6 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the current Minnesota Fire Code Provisions. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During facility tour on September 16, 2025, from 9:27 a.m. through 10:38 a.m., with director of maintenance (DM)-E the surveyor observed fire rated doors that were not maintained to automatically close and latch as designed in the following locations. Resident rooms 215, 209, 101 and 412 had 20-minute fire rated doors with the door closers removed so the doors did not automatically close and latch. DM-E stated that residents wanted the closers removed because they were too hard to operate. Twenty-minute fire rated doors were propped open in the following locations: maintenance office, break room, life enrichment room, and sales directors office. State Fire Code in Minnesota Rules, chapter	0 775		

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0 775	Continued From page 7 7511 requires fire rated doors be maintained to automatically close and latch as designed. DM-E verified the above findings while accompanying on the tour and stated they understood the requirements. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		
01370 SS=G	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; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional;	01370		

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01370	Continued From page 8 (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 staff training and competency related to change of condition with notification to the registered nurse (RN) was implemented for one of one resident (R2) who fell and sustained a left hip fracture. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) 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: During the entrance conference on September 15, 2025, at 10:41 a.m., assisted living director in residence (ALDIR)-A stated they did not have a RN onsite at this time, and they were in the process of hiring; the previous RN's last day was September 4, 2025. ALDIR-A stated a regional	01370		

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01370	Continued From page 9 licensed practical nurse (LPN)-C was flying to Minnesota this afternoon to work part-time onsite temporarily until a RN was hired. ALDIR-A further stated they were utilizing the regional director of health services (RDHS)-B, who resided in another state, to cover on-call and also to complete assessments. ALDIR-A placed a call to RDHS-B who was then included in the entrance conference via phone. RDHS-B stated if a resident falls, the RN on-call is notified. RDHS-B further stated after every fall, an internal incident report is completed and a quality step is completed by the nurse for root cause of the fall. 72-hour monitoring with documentation of the resident's status is also initiated after each fall. R2's diagnoses included hemiplegia (severe or complete one-sided loss of strength or paralysis) and hemipareses (slight weakness on one side of the body) related to a CVA (cerebral vascular accident/stroke) affecting left non-dominant side, chronic obstruction pulmonary disease (COPD), and history of falls. R2's Individual Service Plan dated October 1, 2024, indicated R2 received services including medication administration, housekeeping, laundry, and assistance with bathing, transfers, and escorts to meals and activities. R2's incident note dated September 2, 2025, at 5:11 a.m. and completed by unlicensed personnel (ULP)-G, read: "She fall off the wheelchair, she try to reaching something on her dresser. She have litter (sic) cut on her right Arm, we put bend (sic) on it. And her left hip hard, I notify his son, he say call 911 I will be on my way. We call [resident care coordinator (RCC)-J first name] she not answer her call. I	01370		

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01370	Continued From page 10 took blood pressure, 201/94 Temperature 97.4 Pulse 97 Resident's Bedroom" R2's Incident Report - Fall dated September 2, 2025, completed by ALDIR-A, included the above documentation. The incident report further indicated R2 complained of pain, and had a skin tear to the right forearm and bruising to right thigh. The incident report also indicated the community health director/designee was notified. R2's After Visit Summary dated September 9, 2025, indicated: Hip fracture (greater trochanter). Non-operative management. Per orthopedics, "weight bearing as tolerated" - and avoid significant abduction (swinging the left leg outward at the hip notably). Similarly, avoid crossing the leg past midline (significant adduction). On September 16, 2025, at 8:42 a.m., the surveyor observed ULP-D setting up and administering medications to R2. ULP-D stated the first medication she was supposed to set-up was an antibiotic that they hadn't received yet; the start date on the order was September 9, 2025. The surveyor prompted ULP-D to ask the nurse what the status of the order was. ULP-D stated they didn't have a nurse onsite; the surveyor informed ULP-D that LPN-C was filling in and was in the building at this time. ULP-D and the surveyor went to LPN-C's office and ULP-D informed her of the missing medication. LPN-C pulled up R2's electronic record and informed ULP-D that the medication was acetaminophen (a pain reliever-generic version of Tylenol) 325 milligrams (mg) two tablets four times a day for 10 days, not an antibiotic, and she would follow-up on the order. ULP-D and the	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 11 surveyor then returned to the medication cart and ULP-D set-up R2's scheduled morning medications. While setting up the medications, ULP-D shared with the surveyor that R2 had fallen a couple weeks ago and fractured her hip. ULP-D further stated R2 did not receive surgical intervention and was surprised that the only medication ordered for pain was PRN (as needed) Tylenol. ULP-D and surveyor went to R2's apartment to administer the medications. R2 was lying in bed; ULP-D assisted the resident to a sitting position. R2 was observed to have a large Band-Aid on her right lower arm. She had on a short nightgown and was observed to have a large purple bruise on the inner aspect of her left upper leg from the knee extending up to the resident's groin area. ULP-D stated the bruise started out as softball size by the left knee after R2 had fallen and continued to increase in size. ULP-D stated she called R2's family member (FM)-L on September 9, 2025, as she was concerned about the increased bruising. FM-L directed ULP-D to call 911 and have the bruise evaluated in the emergency department (ED). ULP-D further stated since R2 was only receiving Tylenol for pain, that was another good reason for R2 to be re-evaluated in the ED. The surveyor asked R2 how she fell. R2 stated she was going into the bathroom in her manual w/c and bent down to pick up her briefs and fell. R2 did not have her pendant on as it went off one time by accident during the night and everyone came running. R2 felt bad about it, so she started to keep the pendant on the bedside table. R2 stated she had to crawl out of the bathroom to get to the pendant to call for help. R2 was wearing it at this time and stated now she doesn't take it off.	01370		

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	30723	A. BUILDING: _____ B. WING _____	09/18/2025

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01370	Continued From page 12 R2's progress notes did not include any 72-hour follow-up notes from the fall on September 2, 2025. R2's progress note dated September 8, 2025, at 5:30 p.m. written by ULP-F, read: "She has a bruise on her left leg inner thigh. The bruise starts below her groin area and goes to about her knee. Please keep an eye on the bruise." R2's progress note dated September 9, 2025, at 10:42 p.m., written by ULP-D, read: "Resident has returned to the building she is in pain needs help getting dressed and toileting." As of September 15, 2025, there were no further progress notes written. R2's medication administration record (MAR) dated September 2025, indicated R2 requested and received PRN acetaminophen extra strength 1000 mg one time daily on September 2, 3, 4, 5, 7, 11, 12, and 14, for complaints of pain. On September 16, 2025, at 11:00 a.m., LPN-C stated she called the pharmacy related to R2's PRN acetaminophen order dated September 9, 2025. LPN-C was informed R2's insurance didn't cover the cost of the medication; a fax was sent to the licensee with this information, although it was never followed up on. LPN-C further stated being unable to locate the fax. LPN-C requested the pharmacy to re-send the fax and also requested they fill R2's acetaminophen order and bill it to the licensee. LPN-C stated this would have been handled by the nurse, although without a nurse in the building, there was a disconnect with the communication, and staff should have reached out to RDHS-B who was	01370		

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01370	Continued From page 13 on-call. LPN-C stated now with her being onsite (first full day today), she would be responsible for these things; however, prior to her coming, it would have been the responsibility of RDHS-B. The surveyor voiced concerns related to R2's fractured left hip and large bruise on her left leg. LPN-C stated being unaware of R2's recent hip fracture and bruising. On September 16, 2025, at 12:56 p.m., R2 stated when she fell on September 2, 2025, she cracked or re-injured something in her left hip. The medical doctor and orthopaedic doctor consulted together along with FM-L, and it was decided not to perform surgery. R2 stated she initially had pain, but the pain was gone now. "They've been giving me Tylenol". R2 stated she also sustained an open area on her right arm from the fall, which they put a bandage on that night. R2 stated she waited a few days to see if someone would check on it because it was a "raw sore under there". R2 stated she eventually took the bandage off herself to check on it, put coconut oil on it and re-bandaged it herself which she has continued to do. When asked about the bruising to her left upper leg, R2 stated, "That's why that one girl sent me back in". R2 stated her left leg hurts when they put her into bed and elevate her legs on "that elevation thing", otherwise she no longer has pain. FM-L was also present during the interview, he stated ULP-D called him on September 9, 2025, around 11:00 a.m., about the bruising; he directed her to call 911 and send R2 to the ED. FM-L was on vacation at the time and wanted to speak to a nurse. FM-L called ALDIR-A who said she would have RDHS-B return his call. FM-L stated RDHS-B returned his call around 7:00 p.m. mountain time; she indicated to FM-L she was	01370		

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01370	Continued From page 14 currently in Wisconsin. FM-L was concerned there was not a nurse in the building to check on the bruising. FM-L stated he talked with RDHS-B at length about the bruising. FM-L further stated RDHS-B had ensured him another regional nurse would be coming onsite this week; however, he hadn't seen one yet. The surveyor let FM-L know LPN-C was onsite that day. FM-L stated to his knowledge there was never a nurse who had checked on R2 or looked at her right arm wound or left leg bruising. At 1:28 p.m., ULP-F entered R2's room to see if she needed anything. ULP-F stated staff were monitoring the bruising on R2's left leg visually, noting where it started and approximately the size and how it continued to spread. ULP-F further stated they were not measuring or documenting on the size of the bruise. R2's medication administration record (MAR) dated September 2025, included the following order: acetaminophen 500 mg take two tablets (1000 mg) orally one time PRN for pain. On September 16, 2025, at 2:04 p.m., ULP-D stated they had been giving R2 her PRN Tylenol for pain after her fall. R2 would never admit to having pain but would ask for the Tylenol which was over the counter in a bottle. ULP-D stated after the fall, R2 had a really difficult time with transfers and needed more assistance; especially last Tuesday (September 9, 2025) when she ended up going to the ED. R2 needed help getting dressed and transferring and was wincing a lot. ULP-D further stated she actually had to have R2 lay down on the bed that day in order to get her pants on. That was when she called FM-L with concerns related to R2's bruising on the left leg. ULP-D also stated	01370		

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01370	Continued From page 15 having concerns with R2 only receiving Tylenol for pain for a broken hip; FM-L directed ULP-D to call 911 and have R2 sent to the ED. ULP-D stated she didn't notify the nurse because, "We didn't have one". ULP-D stated she did notify the managers (ALDIR-A, RCC-J, activity director (AD)-M) that she had talked to FM-L and what his recommendation was. ULP-D stated being unaware she needed to call the current on-call nurse during the day, and she would contact the managers instead. On September 16, 2025, at 2:41 p.m., ULP-F stated staff were advised to contact RDHS-B by phone for anything clinical. ULP-F further stated if she was busy and didn't have the time to call RDHS-B when management was in the building, she would ask management (ALDIR-A, AD-M, or RCC-J) to call the nurse for her for direction. On September 17, 2025, at 9:05 a.m., ALDIR-A stated the former clinical nurse supervisor (CNS)-K went on PTO (paid time off) at the end of August 2025; she was not on-call while on PTO. During the time she was on PTO, the licensee found evidence of concerns with her performance, and CNS-K was put on suspension and then terminated on September 4, 2025. ALDIR-A stated R2's fall on September 2, 2025, was not witnessed. R2 had put her call light on and let ULP-G know that her hip hurt and that she had fallen. ALDIR-A was unsure if R2 was still on the floor when ULP-G entered the room but thought R2 had gotten herself up off the floor. ULP-G called FM-L who wanted R2 transferred to the ED, so the ambulance was called. ALDIR-A stated they received no paperwork related to R2's ED visit following the fall or the visit one week later regarding the bruising. ALDIR-A	01370		

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01370	Continued From page 16 further stated LPN-C had talked with R2 this morning; the resident stated she had paperwork from the ED visits and let LPN-C take a picture of it. ALDIR-A stated being unable to find any other notes regarding R2's fall/bruising or follow up by a nurse. On September 17, 2025, at 9:20 a.m., LPN-C stated being unaware of R2's fall with fracture until mentioned by the surveyor the day before. LPN-C stated she called RDHS-B about it and RDHS-B also was unaware of R2's hip fracture. LPN-C stated they had no paperwork from the ED visit on September 2, 2025, following the fall, or the subsequent visit to the ED related to the post fall bruising on September 9, 2025. LPN-C stated there is no documentation of a nurse completing an assessment of the resident following the fall or of the bruising. LPN-C stated R2's PRN acetaminophen 325 mg, 2 tabs by mouth every six hours for 10 days was ordered by the ED physician on September 9, 2025, and not filled until September 16, 2025, after the surveyor brought it to her attention. R2 was only receiving the acetaminophen 1000 mg PRN once daily for pain control and not the scheduled dose as ordered. LPN-C stated she spoke with R2 this morning and the resident felt that her pain was being controlled with the scheduled acetaminophen. At 10:02 a.m., the surveyor and LPN-C interviewed R2 in her apartment. LPN-C reminded R2 that she had a PRN Tylenol order that she could utilize if having breakthrough pain. R2 stated she wasn't having any pain now but when she did pain she had to "Beg for it". The surveyor asked R2 if she was having pain after the fall with fracture and she stated, "Oh yeah". On September 17, 2025, at 11:10 a.m., RDHS-B	01370		

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01370	Continued From page 17 stated she was not informed of R2's fall with fracture on September 2, 2025, although, was informed of the bruising on September 9, 2025. RDHS-B stated she had received a text from ALDIR-A indicating FM-L was upset and wanted to speak with a nurse. RDHS-B called FM-L who indicated R2 had slipped and hadn't told anybody; FM-L was concerned about R2's bruising. RDHS-B stated she reviewed R2's medications to see if she was prescribed an blood thinners, which she was not. FM-L informed RDHS-B that R2's scans completed in the ED came back ok and was reassured by this. RDHS-B let FM-L know that the specialist LPN would be coming to the facility and would touch base with R2. FM-L did not share with RDHS-B that R2 had previously been diagnosed with a left hip fracture. RDHS-B stated to the surveyor that their process for any fall or change of condition is to notify the RN; any fall with a significant injury would require an RN to come and assess the resident. RDHS-B stated if she had known R2 had fallen and sustained a hip fracture she would have instructed the RN at their sister facility to drive to the facility and assess R2. RDHS-B further stated she also would have expected staff to report the bruise to her. Related to documentation following a fall, RDHS-B stated for 72-hours after a fall staff are to check on the resident and document any changes. This wasn't completed for R2. RDHS-B stated protocols were not followed for R2 related to notification of the fall, obtaining ED records, monitoring and documenting R2's status including pain control following the fall, notification of the increased bruising, and notification of pain medication not being filled. On September 17, 2025, at 1:45 p.m., ULP-G	01370		

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01370	Continued From page 18 stated on September 2, 2025, R2 pushed her pendant around 2:00 a.m. R2 was on the floor when ULP-G went into her apartment. R2 stated to ULP-G that she had fallen during the previous shift while trying to get back into bed after toileting; she further stated her hip was hurting. ULP-G stated he assisted R2 into bed, then called FM-L who indicated would come to take R2 to the ED. ULP-G also stated he asked R2 if she needed anything for pain and she requested Tylenol, which was administered. R2 indicted to ULP-G that she didn't think she could make it into FM-L's vehicle. ULP-G called FM-L to let him know this and FM-L advised ULP-G to call 911. ULP-G stated he called RCC-J to inform her of R2's fall as she was on-call that night, although he did not get a hold of her. ULP-G further stated he sent a text message to CNS-K so she would get the message in the morning. ULP-G stated they have another nurse on-call in Seattle Washington who may be on-call if RCC-J or CNS-K wasn't on call. If there are any updates now with residents we need to contact RCC-J or ALDIR-A. Related to falls, ULP-G stated, "first we call the family then the person on-call. Not sure who I'm supposed to call for on-call now that CNS-K is gone, but I do know I can call RCC-J or ALDIR-A. If the nurse from Seattle isn't on-call then we can't call her, RDHS-B is the nurse in Seattle." ULP-G further stated, "I worked last night, I don't think there was anything posted that we are supposed to call RDHS-B, I would call ALDIR-A." On September 17, 2025, at 2:16 p.m., ALDIR-A stated she did not know anything about R2's status following her fall on September 2, 2025, because when FM-L bought R2 back to her apartment, he didn't talk to her. ALDIR-A stated	01370		

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01370	Continued From page 19 it wasn't until later that she found out R2's hip was "cracked". She had informed RDHS-B of R2's increased left leg bruising on September 9, 2025, although was unaware at that time of R2's cracked hip. On September 17, 2025, at 3:07 p.m., ULP-H and ULP-I stated when CNS-K was still employed by the licensee, she and RCC-J would take turns being on-call. Now the direction given is to call RDHS-B for any clinical concerns and to call ALDIR-A for staffing concerns. The surveyor observed the posting of this information at this time at the desk and on the wall in the nurses station. When asked when this became effective, ULP-I stated she couldn't really say as it's gone back and forth on if RCC-J was able to be on-call or not. "Now they're saying she isn't". On September 17, 2025, at 3:59 p.m., RCC-J stated normally staff would not call her if a resident fell as she's not an RN; they would have called CNS-K when still employed by the licensee. RCC-J stated everyone knew they were supposed to call the RN for anything clinical including falls, as this had been covered in several team meetings. If CNS-K was on PTO, then staff were directed to call RDHS-B. If they were uncomfortable calling RDHS-B, then the could call ALDIR-A. RCC-J further stated she was only on-call for scheduling conflicts and stopped being on-call altogether around August 27, 2025, as this was not in her job description. RCC-J also stated upon review of her phone records, she had not received a call from ULP-G the morning of September 2, 2025. At the time of R2's fall, ULP did not follow the proper procedure for notifying the RN of the	01370		

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01370	Continued From page 20 change in condition, thus had the potential to cause more than minimal harm. The licensee's Change of Condition policy effective November 1, 2014, indicated: Any changes in a Resident's physical, mental, or emotional condition are promptly recognized, reported, evaluated, and addressed by the Community. Staff members are responsible for monitoring and reporting changes, and the licensed nurse or their designee is accountable for timely follow-up, appropriate interventions, and documentation. 1. Reporting a Change in Condition: A. Any staff member who observes or suspects a change in a Resident's condition must immediately notify a licensed nurse or an appropriately trained designee. TIME PERIOD FOR CORRECTION: Two (2) days	01370		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be	01620		

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01620	Continued From page 21 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 the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the	01620		

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01620	Continued From page 22 licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment not to exceed 90 calendar days from the last assessment, for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 R1's diagnoses included incomplete paraplegia (partial paralysis of the lower body), muscle weakness, hypertension (high blood pressure), and chronic pain syndrome. R1's Individual Service Plan dated December 26, 2024, indicated R1 received services including medication administration, housekeeping, laundry, and assistance with bathing, dressing, transfers, and toileting. R1's last three assessments were requested. Assessments completed December 26, 2024, March 18, 2025, and June 20, 2025, were provided. 94 days had passed between the March and June assessments, thus exceeding 90 calendar days. R2 R2's diagnoses included hemiplegia (severe or complete one-sided loss of strength or paralysis)	01620		

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01620	Continued From page 23 and hemipareses (slight weakness on one side of the body) related to a CVA (cerebral vascular accident/stroke) affecting left non-dominant side, chronic obstruction pulmonary disease (COPD), and history of falls. R2's Individual Service Plan dated October 1, 2024, indicated R2 received services including medication administration, housekeeping, laundry, and assistance with bathing, transfers, and escorts to meals and activities. R2's last three assessments were requested. Assessments completed December 24, 2024, March 19, 2025, and June 23, 2025, were provided. 96 days had passed between the March and June assessments, thus exceeding 90 calendar days. On September 18, 2025, at 2:01 p.m., regional director of health services (RDHS)-B stated R1 and R2's last two 90-day assessments had not been completed within 90 days as required. The licensee's Resident Evaluation and Service Plan policy revised March 10, 2023, indicated: 8. Following the initial evaluation period, routine reevaluations will be conducted every 6 months (semi-annually) or when a change of condition has been identified, resulting in a change of care needs, unless otherwise indicated by state specific guidelines. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		

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	30723	A. BUILDING: _____ B. WING _____	09/18/2025

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01650	Continued From page 24	01650		
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 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 two of two residents' (R1, R2) service plans included all the required content.	01650		

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01650	Continued From page 25 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 R1's diagnoses included incomplete paraplegia (partial paralysis of the lower body), muscle weakness, hypertension (high blood pressure), and chronic pain syndrome. R1's Individual Service Plan dated December 26, 2024, indicated R1 received services including medication administration, housekeeping, laundry, and assistance with bathing, dressing, transfers, and toileting. R1's service plan lacked the following content: - the identification of staff or categories of staff who will provide the services for medication administration, toileting, housekeeping, and laundry. R2 R2's diagnoses included hemiplegia (severe or complete one-sided loss of strength or paralysis) and hemipareses (slight weakness on one side of the body) related to a CVA (cerebral vascular accident/stroke) affecting left non-dominant side, chronic obstruction pulmonary disease (COPD), and history of falls.	01650		

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01650	Continued From page 26 R2's Individual Service Plan dated October 1, 2024, indicated R2 received services including medication administration, housekeeping, laundry, and assistance with bathing, transfers, and escorts to meals and activities. R2's medication administration record (MAR) dated September 2025, included: - Assist resident with TED (thromboembolic deterrent - used to prevent blood clots and swelling in the legs) hose every AM. R2's service plan lacked the following content: - the identification of staff or categories of staff who will provide the services for medication administration, housekeeping, and laundry; and - assistance with TED stockings. On September 16, 2025, at 3:09 p.m., licensed practical nurse (LPN)-C reviewed R1 and R2's service plans and stated it did not include specific staff who were responsible for medication administration, housekeeping, and laundry for R1 and R2, and also for toileting for R1. LPN-C further stated R2's service plan did not include assistance with TED stockings. The licensee's Resident Evaluation and Service Plan policy revised March 10, 2023, indicated: An individualized service plan, addressing all needs identified during the initial evaluation, will be completed for each Resident, including daycare and respite residents, prior to or at admission, following state specific guidelines. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01650		

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01700 SS=D	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management assessment to include all required content for one of two residents (R2), prior to providing medication management services.	01700		

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01700	Continued From page 28 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: During the entrance conference on September 15, 2025, at 10:41 a.m. regional director of health services (RDHS)-B stated the licensee provided medication management services to the residents in the facility. R2's diagnoses included hemiplegia (severe or complete one-sided loss of strength or paralysis) and hemipareses (slight weakness on one side of the body) related to a CVA (cerebral vascular accident/stroke) affecting left non-dominant side, chronic obstruction pulmonary disease (COPD), and history of falls. R2's Individual Service Plan dated October 1, 2024, indicated R2 received services including medication administration. R2's medication administration record (MAR) dated September 2025, included the following medications: one muscle relaxant, three vitamin supplements, one antidepressant, one inhaler, two potassium supplements, one diuretic (water pill), one anticonvulsant, one beta blocker (high blood pressure), and one analgesic.	01700		

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01700	Continued From page 29 R2's current quarterly assessment dated June 16, 2025, indicated R2 had an order for the community to assist with medications. The assessment further indicated medication level of care was a Level 1: Basic Medication pass of two medication passes daily. R2's record lacked evidence the RN conducted a face-to-face review of all medications R2 was known to be taking to include interventions to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. On September 17, 2025, at 10:02 a.m., licensed practical nurse (LPN)-C stated during the quarterly assessment, the nurse goes over all of the resident's medications and inputs them into a form that is faxed to the provider to review for accuracy and also to add if there are any changes. The provider makes the changes (if any) and faxes the form back to the licensee; this would be considered the medication assessment. At 10:48 a.m., LPN-C stated she was still looking for the last quarterly medication review for R2. LPN-C reviewed R2's last quarterly nursing assessment and stated it only included if the resident did or did not receive assistance with medications and also which level of care they received. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		

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01760	Continued From page 30	01760		
01760 SS=J	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medication was administered as prescribed for one of two residents (R2) and failed to follow-up on medication administration practices when R2's newly ordered pain medication was not filled for seven days until identified by the surveyor. This resulted in R2's pain not being properly managed following a left hip fracture. This practice resulted in a level four violation (a violation that harmed a resident's health or safety, not including serious injury or death, or a violation that was likely to lead to serious injury 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).	01760		

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01760	Continued From page 31 The findings include: During the entrance conference on September 15, 2025, at 10:41 a.m., assisted living director in residence (ALDIR)-A stated they did not have a RN onsite at this time and were in the process of hiring; the previous RN's last day was September 4, 2025. ALDIR-A stated a regional licensed practical nurse (LPN)-C was flying to Minnesota this afternoon to work part-time onsite temporarily until a RN was hired. ALDIR-A further stated they were utilizing the regional director of health services (RDHS)-B, who resided in another state, to cover on-call and also to complete assessments. ALDIR-A placed a call to RDHS-B who was then included in the entrance conference via phone. RDHS-B stated if a resident falls, the RN on-call is to be notified. RDHS-B further stated after every fall, an internal incident report is completed and a quality step is completed by the nurse for root cause of the fall. 72-hour monitoring with documentation of the resident's status is also initiated after each fall. R2's diagnoses included hemiplegia (severe or complete one-sided loss of strength or paralysis) and hemipareses (slight weakness on one side of the body) related to a CVA (cerebral vascular accident/stroke) affecting left non-dominant side, chronic obstruction pulmonary disease (COPD), and history of falls. R2's Individual Service Plan dated October 1, 2024, indicated R2 received services including medication administration. R2's incident note dated September 2, 2025, at 5:11 a.m. and completed by unlicensed	01760		

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01760	Continued From page 32 personnel (ULP)-G, read: "She fall off the wheelchair, she try to reaching something on her dresser. She have litter (sic) cut on her right arm, we put bend (sic) on it. And her left hip hard, I notify his son, he say call 911 I will be on my way. We call [resident care coordinator (RCC)-J first name] she not answer her call. I took blood pressure, 201/94 Temperature 97.4 Pulse 97 Resident's Bedroom" R2's Incident Report - Fall dated September 2, 2025, completed by ALDIR-A, included the above documentation. The incident report further indicated R2 complained of pain, and had a skin tear to the right forearm and bruising to right thigh. The incident report also indicated the community health director/designee was notified. R2's After Visit Summary dated September 2, 2025, indicated: Hip fracture (greater trochanter). Non-operative management. Per orthopedics, "weight bearing as tolerated" - and avoid significant abduction (swinging the left leg outward at the hip notably). Similarly, avoid crossing the leg past midline (significant adduction). R2's After Visit Summary dated September 9, 2025, indicated: Your medications have changed. Change how you take: potassium chloride (Klor-Con) - Another medication with the same name was paused. Ask your nurse or doctor if you should take this medication. Pause taking: potassium chloride 10 mEq (milliequivalents) ER (extended release) tablet - Wait to take this until: September 13, 2025. The After Visit Summary also included the following new order: potassium chloride 20 mEq packet. Commonly known as Klor-Con. Take 20 mEq by	01760		

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01760	Continued From page 33 mouth 2 times a day with meals for 3 days. On September 16, 2025, at 8:42 a.m., the surveyor observed ULP-D set up and administer medications to R2. ULP-D stated the first medication she was supposed to set-up was an antibiotic that they hadn't received yet; the start date on the order was September 9, 2025. The surveyor prompted ULP-D to ask the nurse what the status of the order was. ULP-D stated they didn't have a nurse onsite; the surveyor informed ULP-D that LPN-C was filling in and was in the building at this time. ULP-D and the surveyor went to LPN-C's office and ULP-D informed her of the missing medication. LPN-C pulled up R2's electronic record and informed ULP-D that the medication was acetaminophen (a pain reliever-generic version of Tylenol) 325 milligrams (mg) two tablets four times a day for 10 days, not an antibiotic, and she would follow-up on the order. ULP-D and the surveyor returned to the medication cart and ULP-D then set-up R2's scheduled morning medications. The medications set up by ULP-D included: - KCL (potassium chloride) 20 mEq powder for solution. Mix and take one packet by mouth twice daily for three days - potassium CL 10 mEq ER tablet. Take one tablet by mouth once daily While setting up the medications, ULP-D shared with the surveyor that R2 had fallen a couple weeks ago and fractured her hip. ULP-D further stated R2 did not receive surgical intervention and was surprised that the only medication ordered for pain was PRN (as needed) Tylenol. ULP-D and the surveyor went to R2's apartment to administer the medications. R2 was lying in bed. ULP-D assisted R2 to a sitting position. R2 was observed to have a large Band-aid on her	01760		

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01760	Continued From page 34 right lower arm. She had on a short nightgown and was observed to have a large purple bruise on the inner aspect of her left upper leg from the knee extending up to R2's groin area. ULP-D stated the bruise started out as softball size by the left knee after R2 had fallen and continued to increase in size. ULP-D stated she called R2's family member (FM-L) on September 9, 2025, as she was concerned about the increased bruising. FM-L directed ULP-D to call 911 and have the bruise evaluated in the emergency department (ED). ULP-D further stated since R2 was only receiving Tylenol for pain and thought that was another good reason for R2 to be re-evaluated in the ED. R2's progress note dated September 8, 2025, at 5:30 p.m. written by ULP-F, indicated: "She has a bruise on her left leg inner thigh. The bruise starts below her groin area and goes to about her knee. Please keep an eye on the bruise." R2's progress note dated September 9, 2025, at 10:42 p.m., written by ULP-D, read: "Resident has returned to the building she is in pain needs help getting dressed and toileting." R2's medication administration record (MAR) dated September 2025, indicated R2 requested and received PRN acetaminophen extra strength 1000 mg one time daily on September 2, 3, 4, 5, 7, 11, 12, and 14, for complaints of pain. On September 16, 2025, at 11:00 a.m., LPN-C stated she called the pharmacy related to R2's PRN acetaminophen order dated September 9, 2025. LPN-C was informed R2's insurance didn't cover the cost of the medication. A fax was sent to the licensee with this information, although it	01760		

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01760	Continued From page 35 was never followed up on. LPN-C further stated being unable to locate the fax. LPN-C requested the pharmacy re-send the fax and also requested they fill R2's acetaminophen order and bill it to the licensee. LPN-C stated this would have been handled by the nurse; however, without a nurse in the building, there was a disconnect with the communication, and staff should have reached out to RDHS-B, who was on-call. LPN-C stated now with her being onsite (first full day today), she would be responsible for these things; however, prior to her coming, it would have been the responsibility of RDHS-B. The surveyor voiced concerns related to R2's fractured left hip and large bruise on her left leg; LPN-C stated being unaware of R2's recent hip fracture and bruising. On September 16, 2025, at 2:04 p.m., ULP-D stated they had been giving R2 her PRN Tylenol for pain after her fall. R2 would never admit to having pain but would ask for the Tylenol, which was over the counter in a bottle. ULP-D stated after the fall, R2 had a difficult time with transfers and needed more assistance, especially last Tuesday (September 9, 2025) when she ended up going to the ED. R2 needed help getting dressed and transferring and was wincing a lot. ULP-D further stated she actually had to have R2 lay down on the bed that day in order to get her pants on; that was when she called FM-L with concerns related to R2's bruising on the left leg. ULP-D also stated having concerns with R2 only receiving Tylenol for pain for a broken hip. FM-L directed ULP-D to call 911 and have R2 sent to the ED. ULP-D stated she did not notify the nurse because, "We didn't have one". ULP-D stated she did notify the managers (ALDIR-A, RCC-J, activity director (AD)-M) that she had	01760		

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01760	Continued From page 36 talked to FM-L and what his recommendation was. ULP-D stated being unaware she needed to call the current on-call nurse during the day, as she would contact the managers instead. On September 16, 2025, at 3:09 p.m., LPN-C stated she reviewed R2's physician orders and September 2025, MAR which indicated R2 received KC 20 mEq powder for solution. Mix and take one packet by mouth twice daily for three days, along with potassium CL 10 mEq ER tablet. Take one tablet by mouth once daily from September 14, 2025, through September 16, 2025. LPN-C stated this was a medication error and a medication error report would be completed. On September 17, 2025, at 9:20 a.m., LPN-C stated being unaware of R2's fall with fracture until mentioned by the surveyor the day before. LPN-C stated she called RDHS-B about it and RDHS-B also was unaware of R2's hip fracture. LPN-C stated they had no paperwork from the ED visit on September 2, 2025, following the fall, or the subsequent visit to the ED related to the post fall bruising on September 9, 2025. LPN-C stated there is no documentation of a nurse completing an assessment of the resident following the fall or of the bruising. LPN-C stated R2's PRN acetaminophen 325 mg, 2 tabs by mouth every six hours for 10 days was ordered by the ED physician on September 9, 2025, and not filled until September 16, 2025, after the surveyor brought it to her attention. R2 was only receiving the acetaminophen 1000 mg PRN once daily for pain control and not the scheduled dose as ordered. LPN-C stated she spoke with R2 this morning and the resident felt that her pain was being controlled with the scheduled	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30723	A. BUILDING: _____ B. WING _____	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANKATO LODGE SENIOR LIVING	1360 ADAMS STREET MANKATO, MN 56001

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01760	Continued From page 37 acetaminophen. At 10:02 a.m., the surveyor and LPN-C interviewed R2 in her apartment. LPN-C reminded R2 that she had a PRN Tylenol order that she could utilize if having breakthrough pain. R2 stated she wasn't having any pain now but when she did have pain, she had to "Beg for it". The surveyor asked R2 if she was having pain after the fall with fracture and she stated, "Oh yeah". On September 17, 2025, at 11:10 a.m., RDHS-B stated if she had known R2 had fallen and sustained a hip fracture she would have instructed the RN at their sister facility to drive to the facility and assess R2. RDHS-B further stated she also would have expected staff to report the bruise to her. Related to documentation following a fall, RDHS-B stated for 72-hours after a fall, staff are to check on the resident and document any changes, which was not completed for R2. RDHS-B stated protocols were not followed for R2 related to notification of the fall, obtaining ED records, monitoring and documenting R2's status including pain control following the fall, notification of the increased bruising, and notification of pain medication not being filled. The licensee's Medication Management policy revised December 19, 2022, indicated: 12. Medication Errors a. All medication dispensing or administration errors will be investigated. b. All medications are to be dispensed or administrated according to prescribed physician orders. c. When a staff member fails to dispense or administer a medication as prescribed the incident will be investigated.	01760		

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01760	Continued From page 38 d. A plan of correction will be put in place after a medication error occurs. TIME PERIOD FOR CORRECTION: Two (2) days	01760		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes.	01940		

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01940	Continued From page 39 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on September 15, 2025, at 10:41 a.m. regional director of health services (RDHS)-B stated the licensee provided treatment management services to residents, including compression stockings. On September 17, 2025, at 10:02 a.m. R2 was observed seated in power wheelchair in her apartment with TED (thromboembolic deterrent - use to prevent blood clots and swelling in the legs) stockings on lower legs bilaterally. R2's diagnoses included hemiplegia (severe or complete one-sided loss of strength or paralysis) and hemipareses (slight weakness on one side of the body) related to a CVA (cerebral vascular accident/stroke) affecting left non-dominant side, chronic obstruction pulmonary disease (COPD),	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 40 and history of falls. R2's Individual Service Plan dated October 1, 2024, indicated R2 received services including medication administration, housekeeping, laundry, and assistance with bathing, transfers, and escorts to meals and activities. R2's medication administration record (MAR) dated September 2025, included: - Assist resident with TED hose every AM. R2's record lacked a treatment management plan to include the following required content: - procedures for notifying a registered nurse when a problem arose with treatments or therapy services. On September 16, 2025, at 3:09 p.m., licensed practical nurse (LPN)-B was unable to locate evidence of the above required content for R2's TED stockings. A policy related to the individualized treatment or therapy management plan was requested though not received. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be	01970		

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01970	Continued From page 41 provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for one of two residents (R2) receiving treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On September 17, 2025, at 10:02 a.m., the surveyor observed R2 seated in power wheelchair in her apartment with TED (thromboembolic deterrent - use to prevent blood clots and swelling in the legs) stockings on lower legs bilaterally. R2's diagnoses included hemiplegia (severe or complete one-sided loss of strength or paralysis) and hemipareses (slight weakness on one side of the body) related to a CVA (cerebral vascular accident/stroke) affecting left non-dominant side, chronic obstruction pulmonary disease (COPD), and history of falls.	01970		

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01970	Continued From page 42 R2's Individual Service Plan dated October 1, 2024, indicated R2 received services including medication administration, housekeeping, laundry, and assistance with bathing, transfers, and escorts to meals and activities. R2's medication administration record (MAR) dated September 2025, included: - Assist resident with TED hose every AM. R2's record lacked a current provider order for the TED stockings. On September 16, 2025, at 12:35 p.m., and September 18, 2025, at 9:46 a.m., the surveyor emailed licensed practical nurse (LPN)-D and requested evidence of a current order for R2's TED stockings; an order was not provided. A policy related to treatment orders was requested though not received. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		

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

Mankato Lodge
1360 ADAMS STREET
Mankato, MN 56001
Blue Earth County
Parcel:

Phone:

License Info

License: HFID 30723

Risk:
License:
Expires on:
CFPM: Barry Ahl
CFPM #: FM3129; Exp: 06/27/2027

Inspection Info

Report Number: F1028251099
Inspection Type: Full - Single
Date: 9/15/2025 Time: 12:16:53 PM
Duration: minutes
Announced Inspection: Yes
Total Priority 1 Orders: 1
Total Priority 2 Orders: 0
Total Priority 3 Orders: 2
Delivery: Emailed

! **New Order: 2-300 Personal Cleanliness**
2-301.12A *Priority Level: Priority 1 CFP#: 8*
MN Rule 4626.0070A Food employees must clean their hands and exposed portions of their arms for 20 seconds, using soap in a handwashing sink that is properly equipped.
COMMENT: **Employees were observed washing their hands for less than 20 seconds. Ensure that employees are washing for at least 20 seconds.**
Comply By: 9/15/2025 Originally Issued On: 9/15/2025

New Order: 5-500 Refuse and Recyclables
5-501.16C *Priority Level: Priority 3 CFP#: 54*
MN Rule 4626.1255C Provide a waste receptacle at each handwashing sink or group of handwashing sinks if disposable towels are used.
COMMENT: **Provide a trash bin at the kitchen area handwashing sink.**
Comply By: 9/15/2025 Originally Issued On: 9/15/2025

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control
6-501.12A *Priority Level: Priority 3 CFP#: 55*
MN Rule 4626.1520A Clean and maintain all physical facilities clean.
COMMENT: **The ceiling vent next to the dish machine accumulates moisture and must be dried periodically. An accumulation of a mold-like residue was present at the time of inspection and must be removed, cleaned, and sanitized.**
Comply By: 9/15/2025 Originally Issued On: 9/15/2025

Food & Beverage General Comment

This Inspection was conducted in conjunction with the site inspection by the Health Regulation Division.

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 F1028251099 from 9/15/2025

Barry Ahl

Ryan Miller, RS

Public Health Sanitarian 3
507-344-2721
ryan.miller@state.mn.us

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

Temperature Observations/Recordings

Establishment Info

Mankato Lodge
Mankato
County/Group: Blue Earth County

Inspection Info

Report Number: F1028251099
Inspection Type: Full
Date: 9/15/2025
Time: 12:16:53 PM

Food Temperature: Product/Item/Unit: Shrimp**; Temperature Process:** Hot-Holding
Location: Warmer at 140 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Potatoes**; Temperature Process:** Hot-Holding
Location: Warmer at 170 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Beans**; Temperature Process:** Hot-Holding
Location: Warmer at 139 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: Freezer**; Temperature Process:** Ambient Air
Location: Upright Freezer at -5 Degrees F.
Comment:
Violation Issued?: No

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