



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

Electronically Delivered

August 5, 2026

Licensee  
Adith Miller Manor  
885 Mankato Avenue  
Winona, MN 55987

RE: Project Number(s) SL20147016

Dear Licensee:

On July 29, 2026, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on July 24, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the July 24, 2025 survey.

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

At the time of this follow-up survey completed on July 29, 2026, we identified the following violation(s):

**0780-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (1)**

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

The details of the violations noted at the time of this follow-up survey completed on July 29, 2026 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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

**DOCUMENTATION OF ACTION TO COMPLY**

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



### **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>**

We urge you to review these orders carefully. If you have questions, please contact Stephanie Jones de Palma at 651-201-4320.

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

Sincerely,

A handwritten signature in black ink, reading "Stephanie Jones de Palma". The signature is fluid and cursive, with a large, stylized initial 'S'.

Stephanie Jones de Palma, Supervisor  
State Evaluation Team  
Email: [stephanie.jones.de.palma@state.mn.us](mailto:stephanie.jones.de.palma@state.mn.us)  
Telephone: 651-201-4320 Fax: 1-866-890-9290

KKM



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                        |                                                                                                                          |                          |                                                                 |
|---------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|-----------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |                          | (X3) DATE SURVEY COMPLETED<br><br><b>R</b><br><b>07/29/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |                          |                                                                 |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                                 |
| {0 000}                                                       | Initial Comments<br><br>*****ATTENTION*****<br><br>ASSISTED LIVING PROVIDER FOLLOW UP<br>SURVEY<br>INITIAL COMMENTS<br><br>SL20417016-4<br><br>On July 14, 2026, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to surveys completed on May 4, 2026, February 6, 2026, October 20, 2025, and July 23, 2025. At the time of the survey, there were 20 residents; 20 receiving services under the Assisted Living Facility with Dementia Care license. As a result of the follow-up survey, a new order was identified.                                                                                                                                                                                                                                                                                                     | {0 000}                                                                |                                                                                                                          |                          |                                                                 |
| {0 480}<br>SS=F                                               | 144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services<br><br>(a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626.<br>(b) For an assisted living facility with a licensed capacity of ten or fewer residents:<br>(1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation;<br>(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 | {0 480}                                                                |                                                                                                                          |                          |                                                                 |

Minnesota Department of Health

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

TITLE

(X6) DATE



Minnesota Department of Health  
STATE FORM 6899 LHK15 If continuation sheet 2 of 13



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                        |                                                                                                                          |                          |                                                                 |
|---------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|-----------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |                          | (X3) DATE SURVEY COMPLETED<br><br><b>R</b><br><b>07/29/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |                          |                                                                 |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                                 |
| {0 630}                                                       | Continued From page 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | {0 630}                                                                |                                                                                                                          |                          |                                                                 |
| {0 630}<br>SS=E                                               | <p>144G.42 Subd. 6 (b) Compliance with requirements for reporting ma</p> <p>(b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse.</p> <p>This MN Requirement is not met as evidenced by:</p>                                                                                       | {0 630}                                                                |                                                                                                                          |                          |                                                                 |
| {0 780}<br>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> <p>(i) provide smoke alarms in each room used for sleeping purposes;</p> <p>(ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms;</p> <p>(iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics;</p> <p>(iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so</p> | {0 780}                                                                | Not reviewed during this survey.                                                                                         |                          |                                                                 |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                           |                                                                                                                          |  |                                                                    |
|---------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>07/29/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {0 780}                                                       | <p>Continued From page 3</p> <p>that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and</p> <p>(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;</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation and interview, the licensee failed to provide smoke alarms that complied with fire protection requirements.</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>On July 14, 2026, at 10:05 a.m., the surveyor toured the facility with facilities director (FD)-D. During the facility tour, the surveyor observed the following:</p> <p>Smoke detectors were installed inside resident sleeping rooms in the Adith Miller and Roger Metz buildings. FD-D stated during the tour that these</p> | {0 780}                                                                   |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                        |                                                                                                                          |                          |                                                                 |
|---------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|-----------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |                          | (X3) DATE SURVEY COMPLETED<br><br><b>R</b><br><b>07/29/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |                          |                                                                 |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                                 |
| {0 780}                                                       | Continued From page 4<br><br>new smoke detectors were interconnected with the fire alarm system in each building. FD-D stated these smoke detectors would not sound an alarm inside the resident rooms.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | {0 780}                                                                |                                                                                                                          |                          |                                                                 |
| {0 810}<br>SS=F                                               | 144G.45 Subd. 2 (b-f) Fire protection and physical environment<br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:<br>(1) location and number of resident sleeping rooms;<br>(2) staff actions to be taken in the event of a fire or similar emergency;<br>(3) fire protection procedures necessary for residents; and<br>(4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation.<br>(c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter.<br>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.<br>(e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year.<br>(f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill | {0 810}                                                                |                                                                                                                          |                          |                                                                 |



Minnesota Department of Health  
STATE FORM 6899 LHK15 If continuation sheet 6 of 13



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                        |                                                                                                                          |  |                                                                 |
|---------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>R</b><br><b>07/29/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |  |                                                                 |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                        |
| {01620}                                                       | <p>Continued From page 6</p> <p>living services shall not be required to undergo an initial nursing assessment.</p> <p>(b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery.</p> <p>(c) Resident reassessment and monitoring must be conducted by a registered nurse:</p> <p>(1) no more than 14 calendar days after initiation of services;</p> <p>(2) as needed based on changes in the resident's needs; and</p> <p>(3) at least every 90 calendar days.</p> <p>(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.</p> <p>(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</p> | {01620}                                                                |                                                                                                                          |  |                                                                 |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                         |                                                                                                                          |  |                                                                    |
|---------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>20147</b>               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>07/29/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {01620}                                                       | Continued From page 7<br><br>calendar days from the date of the last review.<br>(f) A facility must inform the prospective resident<br>of the availability of and contact information for<br>long-term care consultation services under<br>section 256B.0911, prior to the date on which a<br>prospective resident executes a contract with a<br>facility or the date on which a prospective<br>resident moves in, whichever is earlier.<br><br>This MN Requirement is not met as evidenced<br>by:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | {01620}                                                                                 | Not reviewed during this survey.                                                                                         |  |                                                                    |
| {01640}<br>SS=E                                               | 144G.70 Subd. 4 (a-e) Service plan,<br>implementation and revisions to<br><br>(a) No later than 14 calendar days after the date<br>that services are first provided, an assisted living<br>facility shall finalize a current written service plan.<br>(b) The service plan and any revisions must<br>include a signature or other authentication by the<br>facility and by the resident documenting<br>agreement on the services to be provided. The<br>service plan must be revised, if needed, based on<br>resident reassessment under subdivision 2. The<br>facility must provide information to the resident<br>about changes to the facility's fee for services<br>and how to contact the Office of Ombudsman for<br>Long-Term Care and the Office of Ombudsman<br>for Mental Health and Developmental Disabilities.<br>(c) The facility must implement and provide all<br>services required by the current service plan.<br>(d) The service plan and the revised service plan<br>must be entered into the resident record,<br>including notice of a change in a resident's fees<br>when applicable.<br>(e) Staff providing services must be informed of<br>the current written service plan. | {01640}                                                                                 |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                        |                                                                                         |                                                                                                                          |                                                                 |
|---------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                   |                                                                                                                          | (X3) DATE SURVEY COMPLETED<br><br><b>R</b><br><b>07/29/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b> |                                                                                                                          |                                                                 |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                        | ID<br>PREFIX<br>TAG                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                        |
| {01640}                                                       | Continued From page 8<br><br>This MN Requirement is not met as evidenced by:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                        | {01640}                                                                                 | Not reviewed during this survey.                                                                                         |                                                                 |
| {01760}<br>SS=D                                               | 144G.71 Subd. 8 Documentation of<br>administration of medication<br><br>Each medication administered by the assisted<br>living facility staff must be documented in the<br>resident's record. The documentation must<br>include the signature and title of the person who<br>administered the medication. The documentation<br>must include the medication name, dosage, date<br>and time administered, and method and route of<br>administration. The staff must document the<br>reason why medication administration was not<br>completed as prescribed and document any<br>follow-up procedures that were provided to meet<br>the resident's needs when medication was not<br>administered as prescribed and in compliance<br>with the resident's medication management plan.<br><br>This MN Requirement is not met as evidenced<br>by: |                                                                        | {01760}                                                                                 |                                                                                                                          |                                                                 |
| {01770}<br>SS=F                                               | 144G.71 Subd. 9 Documentation of medication<br>setup<br><br>Documentation of dates of medication setup,<br>name of medication, quantity of dose, times to be<br>administered, route of administration, and name<br>of person completing medication setup must be<br>done at the time of setup.<br><br>This MN Requirement is not met as evidenced<br>by:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                        | {01770}                                                                                 | Not reviewed during this survey.                                                                                         |                                                                 |
|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                        |                                                                                         | Not reviewed during this survey.                                                                                         |                                                                 |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                        |                                                                                                                          |                          |                                                                 |
|---------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|-----------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |                          | (X3) DATE SURVEY COMPLETED<br><br><b>R</b><br><b>07/29/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |                          |                                                                 |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                                 |
| {01880}                                                       | Continued From page 9                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | {01880}                                                                |                                                                                                                          |                          |                                                                 |
| {01880}<br>SS=F                                               | <b>144G.71 Subd. 19 Storage of medications</b><br><br>An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access.<br><br>This MN Requirement is not met as evidenced by:                                                                                                                                                                                                                     | {01880}                                                                |                                                                                                                          |                          |                                                                 |
| {01890}<br>SS=D                                               | <b>144G.71 Subd. 20 Prescription drugs</b><br><br>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.<br><br>This MN Requirement is not met as evidenced by:                                                                                                                                                     | {01890}                                                                | Not reviewed during this survey.                                                                                         |                          |                                                                 |
| {01950}<br>SS=E                                               | <b>144G.72 Subd. 4 Administration of treatments and therapy</b><br><br>Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the | {01950}                                                                | Not reviewed during this survey.                                                                                         |                          |                                                                 |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                        |                                                                                                                          |                          |                                                                 |
|---------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|-----------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |                          | (X3) DATE SURVEY COMPLETED<br><br><b>R</b><br><b>07/29/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |                          |                                                                 |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                                 |
| {01950}                                                       | Continued From page 10<br><br>registered nurse or authorized licensed health professional has:<br>(1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures;<br>(2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and<br><br>This MN Requirement is not met as evidenced by:                                                                                                                                        | {01950}                                                                | Not reviewed during this survey.                                                                                         |                          |                                                                 |
| {01960}<br>SS=D                                               | 144G.72 Subd. 5 Documentation of administration of treatments<br><br>Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs.<br><br>This MN Requirement is not met as evidenced by: | {01960}                                                                |                                                                                                                          |                          |                                                                 |
| {01970}<br>SS=D                                               | 144G.72 Subd. 6 Treatment and therapy orders<br><br>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                                                                                                                                                                                                                                                                                                                                                                                       | {01970}                                                                |                                                                                                                          |                          |                                                                 |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                           |                                                                                                                          |                          |                                                                    |
|---------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>07/29/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                                    |
| {01970}                                                       | Continued From page 11<br><br>description of the treatment or therapy to be<br>provided, and the frequency, duration, and other<br>information needed to administer the treatment or<br>therapy. Treatment and therapy orders must be<br>renewed at least every 12 months.<br><br>This MN Requirement is not met as evidenced<br>by:                                                                                                                                                                                                                                                                                                                                                                                    | {01970}                                                                   | Not reviewed during this survey.                                                                                         |                          |                                                                    |
| {02040}<br>SS=E                                               | <b>144G.81 Subdivision 1 Fire protection and<br/>physical environment</b><br><br>An assisted living facility with dementia care must<br>meet the requirements of section 144G.45 and<br>the following additional requirements:<br>(1) an assessment of safety risks must be<br>performed on and around the property. The<br>safety risks identified by the facility on the<br>assessment must be mitigated to protect the<br>residents from harm. The mitigation efforts must<br>be documented in the facility's records; and<br>(2) the facility shall be protected throughout by an<br>approved supervised automatic sprinkler system<br>by August 1, 2029.<br><br>This MN Requirement is not met as evidenced<br>by: | {02040}                                                                   |                                                                                                                          |                          |                                                                    |
| {02170}<br>SS=E                                               | <b>144G.84 SERVICES FOR RESIDENTS WITH<br/>DEMENTIA</b><br><br>(b) Each resident must be evaluated for activities<br>according to the licensing rules of the facility. In<br>addition, the evaluation must address the<br>following:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | {02170}                                                                   | Not reviewed during this survey.                                                                                         |                          |                                                                    |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                        |                                                                                                                          |                          |                                                                 |
|---------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|-----------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |                          | (X3) DATE SURVEY COMPLETED<br><br><b>R</b><br><b>07/29/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |                          |                                                                 |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                                 |
| {02170}                                                       | <p>Continued From page 12</p> <p>(1) past and current interests;<br/>(2) current abilities and skills;<br/>(3) emotional and social needs and patterns;<br/>(4) physical abilities and limitations;<br/>(5) adaptations necessary for the resident to participate; and<br/>(6) identification of activities for behavioral interventions.</p> <p>(c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs.</p> <p>(d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to:</p> <p>(1) occupation or chore related tasks;<br/>(2) scheduled and planned events such as entertainment or outings;<br/>(3) spontaneous activities for enjoyment or those that may help defuse a behavior;<br/>(4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music;<br/>(5) spiritual, creative, and intellectual activities;<br/>(6) sensory stimulation activities;<br/>(7) physical activities that enhance or maintain a resident's ability to ambulate or move; and<br/>(8) outdoor activities.</p> <p>This MN Requirement is not met as evidenced by:</p> | {02170}                                                                | <p>Not reviewed during this survey.</p>                                                                                  |                          |                                                                 |





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

Electronically Delivered

May 26, 2026

Licensee  
Adith Miller Manor  
885 Mankato Avenue  
Winona, MN 55987

RE: Project Number(s) SL20147016

Dear Licensee:

On May 6, 2026, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on July 24, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the July 24, 2025 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on July 24, 2025, found not corrected at the time of the May 6, 2026, follow-up survey and/or subject to penalty assessment are as follows:

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

The details of the violations noted at the time of this follow-up survey completed on May 6, 2026 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$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 outlined on the state form; however, plans of correction are not required to be submitted for approval.

**IMPOSITION OF FINES**

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

Level 1: no fines or enforcement;

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

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

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



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

### **CORRECTION ORDER RECONSIDERATION PROCESS**

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

To submit a reconsideration request, please visit:

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

### **REQUESTING A HEARING**

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

To submit a hearing request, please visit:

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

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

We urge you to review these orders carefully. If you have questions, please contact Stephanie Jones de Palma at 651-201-4320.

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

Sincerely,

A handwritten signature in black ink, reading "Stephanie Jones de Palma". The signature is fluid and cursive, with the first name "Stephanie" being the most prominent.

Stephanie Jones de Palma, Supervisor  
State Evaluation Team  
Email: [stephanie.jones.de.palma@state.mn.us](mailto:stephanie.jones.de.palma@state.mn.us)  
Telephone: 651-201-4320 Fax: 1-866-890-9290

KKM



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                        |                                                                                                                          |                          |                                                                 |
|---------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|-----------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |                          | (X3) DATE SURVEY COMPLETED<br><br><b>R</b><br><b>05/06/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |                          |                                                                 |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                                 |
| {0 000}                                                       | <p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER FOLLOW UP<br/>SURVEY WITH RE-ISSUE OF ORDERS</p> <p>In accordance with Minnesota Statutes, section<br/>144G.08 to 144G.95, these correction orders are<br/>issued pursuant to a survey.</p> <p>Determination of whether violations are corrected<br/>requires compliance with all requirements<br/>provided at the Statute number indicated below.<br/>When Minnesota Statute contains several items,<br/>failure to comply with any of the items will be<br/>considered lack of compliance.</p> <p>INITIAL COMMENTS:</p> <p>SL20417016-3</p> <p>On May 4, 2026, the Minnesota Department of<br/>Health conducted a follow-up survey at the above<br/>provider to follow-up on orders issued pursuant to<br/>surveys completed on February 6, 2026, October<br/>20, 2025, and July 23, 2025. At the time of the<br/>survey, there were 20 residents; 20 receiving<br/>services under the Assisted Living Facility with<br/>Dementia Care license.As a result of the<br/>follow-up survey, the following order was<br/>reissued.</p> | {0 000}                                                                |                                                                                                                          |                          |                                                                 |
| {0 480}<br>SS=F                                               | <p>144G.41 Subdivision 1 Subd. 1a (a-b) Minimum<br/>requirements; required food services</p> <p>(a) Except as provided in paragraph (b), food<br/>must be prepared and served according to the<br/>Minnesota Food Code, Minnesota Rules, chapter<br/>4626.</p> <p>(b) For an assisted living facility with a licensed</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | {0 480}                                                                |                                                                                                                          |                          |                                                                 |

Minnesota Department of Health

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

TITLE

(X6) DATE



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                        |                                                                                                                          |                          |                                                                 |
|---------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|-----------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |                          | (X3) DATE SURVEY COMPLETED<br><br><b>R</b><br><b>05/06/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |                          |                                                                 |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                                 |
| {0 480}                                                       | Continued From page 1<br><br>capacity of ten or fewer residents:<br>(1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation;<br>(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;<br>(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;<br>(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;<br>(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;<br>(6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb | {0 480}                                                                |                                                                                                                          |                          |                                                                 |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                        |                                                                                                                          |                          |                                                                 |
|---------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|-----------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |                          | (X3) DATE SURVEY COMPLETED<br><br><b>R</b><br><b>05/06/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |                          |                                                                 |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                                 |
| {0 480}                                                       | Continued From page 2<br><br>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.<br><br>This MN Requirement is not met as evidenced by:                                                                                                                                                                                                                                                                                                            | {0 480}                                                                | Not reviewed during this survey.                                                                                         |                          |                                                                 |
| {0 630}<br>SS=E                                               | 144G.42 Subd. 6 (b) Compliance with requirements for reporting ma<br><br>(b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse.<br><br>This MN Requirement is not met as evidenced by: | {0 630}                                                                |                                                                                                                          |                          |                                                                 |
| {0 775}<br>SS=E                                               | 144G.45 Subd. 2. (a) Fire protection and physical environment<br><br>Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | {0 775}                                                                |                                                                                                                          |                          |                                                                 |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                         |                                                                                                                          |  |                                                                 |
|---------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b>                  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>R</b><br><b>05/06/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b> |                                                                                                                          |  |                                                                 |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                        |
| {0 775}                                                       | <p>Continued From page 3</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, record review, and interview, the licensee failed to comply with the requirements of Minnesota State Fire Code Rules, Chapter 7511.</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>On May 4, 2026, the surveyor emailed the licensee and requested a plan of correction for the 0775 tag. On May 4, 2026, licensed assisted living director /registered nurse (LALD/RN)-A responded with a deficiency document and the current resident census.</p> <p>Record review of the available documentation indicated the licensee was working with a licensed architect on preparing a set of construction documents for submittal to Minnesota Department of Health (MDH) Engineering Services and Department of Labor and Industry for alterations to the facility arising from the MDH survey. The licensee was hoping to be submitting these construction documents soon.</p> <p>Record review of the available documentation indicated the egress locking was still not compliant on the day of the follow up. The</p> | {0 775}                                                                                 |                                                                                                                          |  |                                                                 |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                        |                                                                                                                          |  |                                                                 |
|---------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>R</b><br><b>05/06/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |  |                                                                 |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                        |
| {0 775}                                                       | <p>Continued From page 4</p> <p>licensee provided documentation indicating they were working on corrective actions from the initial issue of the order on July 23, 2025, to the current date of the follow-up survey.</p> <p>PREVIOUS SURVEY FINDINGS:<br/>On January 26, 2026, the surveyor emailed the licensee and requested a plan of correction for the 0775 tag.</p> <p>On January 27, 2026, licensed assisted living director /registered nurse (LALD/RN)-A responded:</p> <ul style="list-style-type: none"><li>- A copy of the resident safety policy was provided that included instructions for staff on exiting the buildings and courtyard in the event of an emergency.</li><li>- Copies of the Minnesota Department of Health Engineering plan review submittal forms for both buildings to modify the controlled egress locking systems for compliance with Minnesota State Fire Code Rules, Chapter 7511.</li><li>- Work orders for the project dated July 23, 2025.</li><li>- Fire panel upgrade drawings from the contractor dated January 22, 2026.</li></ul> <p>On February 5, 2026, licensed assisted living director /registered nurse (LALD/RN)-A responded the licensee was working with an architect to bring the courtyard gate locking into compliance. The licensee will be submitting a waiver as soon as drawings are ready and the intent is to hook the fence into a magnetic locking mechanism.</p> <p>Record review of the available documentation indicated the egress locking was still not compliant on the day of the follow up. The licensee provided documentation indicating they were working on corrective actions from the initial</p> | {0 775}                                                                |                                                                                                                          |  |                                                                 |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                        |                                                                                                                          |  |                                                                 |
|---------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>R</b><br><b>05/06/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |  |                                                                 |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                        |
| {0 775}                                                       | <p>Continued From page 5</p> <p>issue of the order on July 23, 2025, to the current date of the follow-up survey.</p> <p>On October 20, 2025, the surveyor emailed the licensee and requested a plan of correction for the 0775 tag.</p> <p>On October 21, 2025, licensed assisted living director /registered nurse (LALD/RN)-A responded:</p> <p>1. All staff were given a key (with the med cart keys and for the RN) to the courtyard area on the last day of survey. We actually had a key, but staff were unaware, so re-education was provided. This was in effect until the combination lock was available.</p> <p>2. The week of September 15, 2025 (note we did not get the survey enforcement package until September 15, 2025), the facilities director (FD)-D contacted two contractors for bids on running the fire alarm lines/unlocks. The invoice for the accepted bid was dated September 17, 2025, and this contractor has been selected to complete the installations.</p> <p>On July 23, 2025, at 10:05 a.m., the surveyor toured the facility with facilities director (FD)-D, master plumber (MP)-K, and administrative assistant (AA)-L. During the facility tour, the surveyor observed the following:</p> <p><b>CONTROLLED EGRESS DOOR LOCKING SYSTEM</b></p> <p>- Electromagnetic locks were installed on the emergency exit doors. Keypads were installed at these doors and required entry of a code into the keypad to unlock. A switch or device was not installed at the nurse station or other approved location that had the capability to break power to all locked doors. During the facility tour interview,</p> | {0 775}                                                                |                                                                                                                          |  |                                                                 |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                        |                                                                                                                          |                          |                                                                 |
|---------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|-----------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |                          | (X3) DATE SURVEY COMPLETED<br><br><b>R</b><br><b>05/06/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |                          |                                                                 |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                                 |
| {0 775}                                                       | <p>Continued From page 6</p> <p>FD-D verified the above listed locking observations. Controlled egress door locking systems must comply with Minnesota State Fire Code Rules, Chapter 7511.</p> <p>- On July 23, 2025, licensed assisted living director/registered nurse (LALD/RN)-A and AA-L provided emergency plan documents. Record review indicated the emergency plan did not include procedures to operate and unlock the controlled egress door locking system. During an interview on July 23, 2025, at 12:50 p.m., LALD/RN-A verified these instructions were not included in the emergency plan.</p> <p><b>OBSTRUCTED EXITING</b><br/>The shared exterior courtyard for both assisted living buildings was enclosed by a fence. In the Adith Miller building, an illuminated exit sign was installed above the door exiting into this courtyard. A lock requiring a key to unlock was installed on the gate leading to the public way. During the facility tour interview, FD-D stated maintenance staff had keys to open the lock and were unsure which other employees had keys. FD-D verified the above listed observations. Gate locking that is part of the egress path must comply with Minnesota State Fire Code Rules, Chapter 7511.</p> | {0 775}                                                                |                                                                                                                          |                          |                                                                 |
| {0 780}<br>SS=E                                               | <p><b>144G.45 Subd. 2 (a) (1) Fire protection and physical environment</b></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> <p>(i) provide smoke alarms in each room used for</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | {0 780}                                                                |                                                                                                                          |                          |                                                                 |



Minnesota Department of Health  
STATE FORM 6899 LHK14 If continuation sheet 8 of 17



Minnesota Department of Health  
STATE FORM 6899 LHK14 If continuation sheet 9 of 17



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                        |                                                                                                                          |                          |                                                                 |
|---------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|-----------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |                          | (X3) DATE SURVEY COMPLETED<br><br><b>R</b><br><b>05/06/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |                          |                                                                 |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                                 |
| {01290}                                                       | Continued From page 9<br><br>(b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12.<br>(c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits.<br><br>This MN Requirement is not met as evidenced by:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | {01290}                                                                | Not reviewed during this survey.                                                                                         |                          |                                                                 |
| {01620}<br>SS=D                                               | 144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring<br><br>(a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment.<br>(b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery.<br>(c) Resident reassessment and monitoring must be conducted by a registered nurse:<br>(1) no more than 14 calendar days after initiation of services; | {01620}                                                                |                                                                                                                          |                          |                                                                 |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                        |                                                                                                                          |                          |                                                                 |
|---------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|-----------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |                          | (X3) DATE SURVEY COMPLETED<br><br><b>R</b><br><b>05/06/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |                          |                                                                 |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                                 |
| {01620}                                                       | Continued From page 10<br><br>(2) as needed based on changes in the resident's needs; and<br>(3) at least every 90 calendar days.<br>(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.<br>(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.<br>(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.<br><br>This MN Requirement is not met as evidenced by: | {01620}                                                                |                                                                                                                          |                          |                                                                 |
| {01640}<br>SS=E                                               | 144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to<br><br>(a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan.<br>(b) The service plan and any revisions must include a signature or other authentication by the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | {01640}                                                                | Not reviewed during this survey.                                                                                         |                          |                                                                 |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                        |                                                                                                                          |                          |                                                                 |
|---------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|-----------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |                          | (X3) DATE SURVEY COMPLETED<br><br><b>R</b><br><b>05/06/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |                          |                                                                 |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                                 |
| {01640}                                                       | Continued From page 11<br><br>facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities.<br>(c) The facility must implement and provide all services required by the current service plan.<br>(d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable.<br>(e) Staff providing services must be informed of the current written service plan.<br><br>This MN Requirement is not met as evidenced by: | {01640}                                                                | Not reviewed during this survey.                                                                                         |                          |                                                                 |
| {01760}<br>SS=D                                               | 144G.71 Subd. 8 Documentation of administration of medication<br><br>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.                                                                                                                                                | {01760}                                                                |                                                                                                                          |                          |                                                                 |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                            |                                                                           |                                                                                                                          |                          |                                                                    |
|---------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION           |                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>05/06/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                            |                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                                    |
| {01760}                                                       | Continued From page 12                                                                                                                                                                                                                                                                                                                     | {01760}                                                                   |                                                                                                                          |                          |                                                                    |
|                                                               | This MN Requirement is not met as evidenced by:                                                                                                                                                                                                                                                                                            |                                                                           | Not reviewed during this survey.                                                                                         |                          |                                                                    |
| {01770}<br>SS=F                                               | 144G.71 Subd. 9 Documentation of medication setup<br><br>Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup.<br><br>This MN Requirement is not met as evidenced by:     | {01770}                                                                   |                                                                                                                          |                          |                                                                    |
| {01880}<br>SS=F                                               | 144G.71 Subd. 19 Storage of medications<br><br>An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access.<br><br>This MN Requirement is not met as evidenced by:    | {01880}                                                                   |                                                                                                                          |                          |                                                                    |
| {01890}<br>SS=D                                               | 144G.71 Subd. 20 Prescription drugs<br><br>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 | {01890}                                                                   |                                                                                                                          |                          |                                                                    |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                         |                                                                                                                          |                          |                                                                    |
|---------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>20147</b>               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>05/06/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b> |                                                                                                                          |                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                                    |
| {01890}                                                       | Continued From page 13<br><br>drug.<br><br>This MN Requirement is not met as evidenced<br>by:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | {01890}                                                                                 | Not reviewed during this survey.                                                                                         |                          |                                                                    |
| {01950}<br>SS=E                                               | <b>144G.72 Subd. 4 Administration of treatments<br/>and therapy</b><br><br>Ordered or prescribed treatments or therapies<br>must be administered by a nurse, physician, or<br>other licensed health professional authorized to<br>perform the treatment or therapy, or may be<br>delegated or assigned to unlicensed personnel by<br>the licensed health professional according to the<br>appropriate practice standards for delegation or<br>assignment. When administration of a treatment<br>or therapy is delegated or assigned to unlicensed<br>personnel, the facility must ensure that the<br>registered nurse or authorized licensed health<br>professional has:<br>(1) instructed the unlicensed personnel in the<br>proper methods with respect to each resident and<br>the unlicensed personnel has demonstrated the<br>ability to competently follow the procedures;<br>(2) specified, in writing, specific instructions for<br>each resident and documented those instructions<br>in the resident's record; and<br><br>This MN Requirement is not met as evidenced<br>by: | {01950}                                                                                 |                                                                                                                          |                          |                                                                    |
| {01960}<br>SS=D                                               | <b>144G.72 Subd. 5 Documentation of<br/>administration of treatments</b><br><br>Each treatment or therapy administered by an<br>assisted living facility must be in the resident<br>record. The documentation must include the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | {01960}                                                                                 |                                                                                                                          |                          |                                                                    |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                        |                                                                                         |                                                                                                                          |                                                                 |
|---------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                   |                                                                                                                          | (X3) DATE SURVEY COMPLETED<br><br><b>R</b><br><b>05/06/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b> |                                                                                                                          |                                                                 |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                        | ID<br>PREFIX<br>TAG                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                        |
| {01960}                                                       | Continued From page 14<br><br>signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs.<br><br>This MN Requirement is not met as evidenced by:                                                                                   |                                                                        | {01960}                                                                                 | Not reviewed during this survey.                                                                                         |                                                                 |
| {01970}<br>SS=D                                               | 144G.72 Subd. 6 Treatment and therapy orders<br><br>There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months.<br><br>This MN Requirement is not met as evidenced by: |                                                                        | {01970}                                                                                 |                                                                                                                          |                                                                 |
| {02040}<br>SS=E                                               | 144G.81 Subdivision 1 Fire protection and physical environment<br><br>An assisted living facility with dementia care must meet the requirements of section 144G.45 and the following additional requirements:<br>(1) an assessment of safety risks must be performed on and around the property. The safety risks identified by the facility on the assessment must be mitigated to protect the                                                                                                                                     |                                                                        | {02040}                                                                                 |                                                                                                                          |                                                                 |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                        |                                                                                                                          |                          |                                                                 |
|---------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|-----------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |                          | (X3) DATE SURVEY COMPLETED<br><br><b>R</b><br><b>05/06/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |                          |                                                                 |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                                 |
| {02040}                                                       | Continued From page 15<br><br>residents from harm. The mitigation efforts must be documented in the facility's records; and<br>(2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029.<br><br>This MN Requirement is not met as evidenced by:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | {02040}                                                                | Not reviewed during this survey.                                                                                         |                          |                                                                 |
| {02170}<br>SS=E                                               | <b>144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA</b><br><br>(b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following:<br>(1) past and current interests;<br>(2) current abilities and skills;<br>(3) emotional and social needs and patterns;<br>(4) physical abilities and limitations;<br>(5) adaptations necessary for the resident to participate; and<br>(6) identification of activities for behavioral interventions.<br>(c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs.<br>(d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to:<br>(1) occupation or chore related tasks;<br>(2) scheduled and planned events such as | {02170}                                                                |                                                                                                                          |                          |                                                                 |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                        |                                                                                                                          |                          |                                                                 |
|---------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|-----------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |                          | (X3) DATE SURVEY COMPLETED<br><br><b>R</b><br><b>05/06/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |                          |                                                                 |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                                 |
| {02170}                                                       | <p>Continued From page 16</p> <p>entertainment or outings;<br/>(3) spontaneous activities for enjoyment or those that may help defuse a behavior;<br/>(4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music;<br/>(5) spiritual, creative, and intellectual activities;<br/>(6) sensory stimulation activities;<br/>(7) physical activities that enhance or maintain a resident's ability to ambulate or move; and<br/>(8) outdoor activities.</p> <p>This MN Requirement is not met as evidenced by:</p> | {02170}                                                                | <p>Not reviewed during this survey.</p>                                                                                  |                          |                                                                 |





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

Electronically Delivered

February 23, 2026

Licensee  
Adith Miller Manor  
885 Mankato Avenue  
Winona, MN 55987

RE: Project Number(s) SL20147016

Dear Licensee:

On January 27, 2026, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on July 24, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the July 24, 2025 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on July 24, 2025, found not corrected at the time of the January 27, 2026, follow-up survey and/or subject to penalty assessment are as follows:

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

The details of the violations noted at the time of this follow-up survey completed on January 27, 2026 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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

**DOCUMENTATION OF ACTION TO COMPLY**

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

**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>**



We urge you to review these orders carefully. If you have questions, please contact Stephanie Jones de Palma at 651-201-4320.

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

Sincerely,

A handwritten signature in black ink, reading "Stephanie Jones de Palma". The signature is fluid and cursive, with a large, stylized initial 'S'.

Stephanie Jones de Palm, Supervisor  
State Evaluation Team  
Email: [stephanie.jones.de.palma@state.mn.us](mailto:stephanie.jones.de.palma@state.mn.us)  
Telephone: 651-201-4320 Fax: 1-866-890-9290

HHH



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                           |                                                                                                                          |                          |                                                                    |
|---------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>01/27/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                                    |
| {0 000}                                                       | Initial Comments<br><br>*****ATTENTION*****<br><br>ASSISTED LIVING PROVIDER FOLLOW UP<br>SURVEY<br><br>INITIAL COMMENTS<br><br>SL20417016-2<br><br>On January 26, 2026 through February 6, 2026,<br>the Minnesota Department of Health conducted a<br>follow-up survey at the above provider to<br>follow-up on orders issued pursuant to a survey<br>completed on October 20, 2025. As a result of<br>the follow-up survey, the following order was<br>reissued.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | {0 000}                                                                   |                                                                                                                          |                          |                                                                    |
| {0 480}<br>SS=F                                               | 144G.41 Subdivision 1 Subd. 1a (a-b) Minimum<br>requirements; required food services<br><br>(a) Except as provided in paragraph (b), food<br>must be prepared and served according to the<br>Minnesota Food Code, Minnesota Rules, chapter<br>4626.<br>(b) For an assisted living facility with a licensed<br>capacity of ten or fewer residents:<br>(1) notwithstanding Minnesota Rules, part<br>4626.0033, item A, the facility may share a<br>certified food protection manager (CFPM) with<br>one other facility located within a 60-mile radius<br>and under common management provided the<br>CFPM is present at each facility frequently<br>enough to effectively administer, manage, and<br>supervise each facility's food service operation;<br>(2) notwithstanding Minnesota Rules, part<br>4626.0545, item A, kick plates that are not<br>removable or cannot be rotated open are allowed<br>unless the facility has been issued repeated<br>correction orders for violations of Minnesota | {0 480}                                                                   |                                                                                                                          |                          |                                                                    |

Minnesota Department of Health

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

TITLE

(X6) DATE



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                           |                                                                                                                          |                          |                                                                    |
|---------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>01/27/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                                    |
| {0 480}                                                       | <p>Continued From page 1</p> <p>Rules, part 4626.1565 or 4626.1570;<br/>(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;<br/>(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;<br/>(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;<br/>(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<br/>(7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door.</p> <p>This MN Requirement is not met as evidenced by:</p> | {0 480}                                                                   | Not reviewed during this survey.                                                                                         |                          |                                                                    |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                        |                                                                                                                          |                          |                                                                 |
|---------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|-----------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |                          | (X3) DATE SURVEY COMPLETED<br><br><b>R</b><br><b>01/27/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |                          |                                                                 |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                                 |
| {0 630}                                                       | Continued From page 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | {0 630}                                                                |                                                                                                                          |                          |                                                                 |
| {0 630}<br>SS=E                                               | <p>144G.42 Subd. 6 (b) Compliance with requirements for reporting ma</p> <p>(b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse.</p> <p>This MN Requirement is not met as evidenced by:</p> | {0 630}                                                                |                                                                                                                          |                          |                                                                 |
| {0 775}<br>SS=E                                               | <p>144G.45 Subd. 2. (a) Fire protection and physical environment</p> <p>Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, record review, and interview, the licensee failed to comply with the requirements of Minnesota State Fire Code Rules, Chapter 7511.</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</p>       | {0 775}                                                                | Not reviewed during this survey.                                                                                         |                          |                                                                 |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                        |                                                                                                                          |                          |                                                                 |
|---------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|-----------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |                          | (X3) DATE SURVEY COMPLETED<br><br><b>R</b><br><b>01/27/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |                          |                                                                 |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                                 |
| {0 775}                                                       | <p>Continued From page 3</p> <p>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>On January 26, 2026, the surveyor emailed the licensee and requested a plan of correction for the 0775 tag.</p> <p>On January 27, 2026, licensed assisted living director /registered nurse (LALD/RN)-A responded:</p> <ul style="list-style-type: none"><li>- A copy of the resident safety policy was provided that included instructions for staff on exiting the buildings and courtyard in the event of an emergency.</li><li>- Copies of the Minnesota Department of Health Engineering plan review submittal forms for both buildings to modify the controlled egress locking systems for compliance with Minnesota State Fire Code Rules, Chapter 7511.</li><li>- Work orders for the project dated July 23, 2025.</li><li>- Fire panel upgrade drawings from the contractor dated January 22, 2026.</li></ul> <p>On February 5, 2026, licensed assisted living director /registered nurse (LALD/RN)-A responded the licensee was working with an architect to bring the courtyard gate locking into compliance. The licensee will be submitting a waiver as soon as drawings are ready and the intent is to hook the fence into a magnetic locking mechanism.</p> <p>Record review of the available documentation indicated the egress locking was still not compliant on the day of the follow up. The licensee provided documentation indicating they</p> | {0 775}                                                                |                                                                                                                          |                          |                                                                 |



Minnesota Department of Health

|                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                 |                                                                                                                          |                          |                                                   |
|--------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|---------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>20147 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |                          | (X3) DATE SURVEY COMPLETED<br><br>R<br>01/27/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>ADITH MILLER MANOR |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>885 MANKATO AVENUE<br>WINONA, MN 55987                                          |                          |                                                   |
| (X4) ID<br>PREFIX<br>TAG                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                   |
| {0 775}                                                | <p>Continued From page 4</p> <p>were working on corrective actions from the initial issue of the order on July 23, 2025, to the current date of the follow-up survey.</p> <p>Previous survey findings:</p> <p>On October 20, 2025, the surveyor emailed the licensee and requested a plan of correction for the 0775 tag.</p> <p>On October 21, 2025, licensed assisted living director /registered nurse (LALD/RN)-A responded:</p> <p>1. All staff were given a key (with the med cart keys and for the RN) to the courtyard area on the last day of survey. We actually had a key, but staff were unaware, so re-education was provided. This was in effect until the combination lock was available.</p> <p>2. The week of September 15, 2025 (note we did not get the survey enforcement package until September 15, 2025), the facilities director (FD)-D contacted two contractors for bids on running the fire alarm lines/unlocks. The invoice for the accepted bid was dated September 17, 2025, and this contractor has been selected to complete the installations.</p> <p>On July 23, 2025, at 10:05 a.m., the surveyor toured the facility with facilities director (FD)-D, master plumber (MP)-K, and administrative assistant (AA)-L. During the facility tour, the surveyor observed the following:</p> <p>CONTROLLED EGRESS DOOR LOCKING SYSTEM</p> <p>- Electromagnetic locks were installed on the emergency exit doors. Keypads were installed at these doors and required entry of a code into the keypad to unlock. A switch or device was not</p> | {0 775}                                                         |                                                                                                                          |                          |                                                   |



Minnesota Department of Health

|                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                 |                                                                                                                          |                          |                                                   |
|--------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|---------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>20147 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |                          | (X3) DATE SURVEY COMPLETED<br><br>R<br>01/27/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>ADITH MILLER MANOR |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>885 MANKATO AVENUE<br>WINONA, MN 55987                                          |                          |                                                   |
| (X4) ID<br>PREFIX<br>TAG                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                   |
| {0 775}                                                | Continued From page 5<br><br>installed at the nurse station or other approved location that had the capability to break power to all locked doors. During the facility tour interview, FD-D verified the above listed locking observations. Controlled egress door locking systems must comply with Minnesota State Fire Code Rules, Chapter 7511.<br><br>- On July 23, 2025, licensed assisted living director/registered nurse (LALD/RN)-A and AA-L provided emergency plan documents. Record review indicated the emergency plan did not include procedures to operate and unlock the controlled egress door locking system. During an interview on July 23, 2025, at 12:50 p.m., LALD/RN-A verified these instructions were not included in the emergency plan.<br><br>OBSTRUCTED EXITING<br>The shared exterior courtyard for both assisted living buildings was enclosed by a fence. In the Adith Miller building, an illuminated exit sign was installed above the door exiting into this courtyard. A lock requiring a key to unlock was installed on the gate leading to the public way. During the facility tour interview, FD-D stated maintenance staff had keys to open the lock and were unsure which other employees had keys. FD-D verified the above listed observations. Gate locking that is part of the egress path must comply with Minnesota State Fire Code Rules, Chapter 7511. | {0 775}                                                         |                                                                                                                          |                          |                                                   |
| {0 780}<br>SS=E                                        | 144G.45 Subd. 2 (a) (1) Fire protection and physical environment<br><br>(a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | {0 780}                                                         |                                                                                                                          |                          |                                                   |



Minnesota Department of Health  
STATE FORM 6899 LHK13 If continuation sheet 7 of 16



Minnesota Department of Health  
STATE FORM 6899 LHK13 If continuation sheet 8 of 16



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                        |                                                                                                                          |                          |                                                                 |
|---------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|-----------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |                          | (X3) DATE SURVEY COMPLETED<br><br><b>R</b><br><b>01/27/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |                          |                                                                 |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                                 |
| {01290}                                                       | Continued From page 8<br><br>245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information.<br>(b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12.<br>(c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits.<br><br>This MN Requirement is not met as evidenced by:<br>Not reviewed during this survey.                                                                                                                                                                                                                                                                                     | {01290}                                                                |                                                                                                                          |                          |                                                                 |
| {01620}<br>SS=D                                               | 144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring<br><br>(a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment.<br>(b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery.<br>(c) Resident reassessment and monitoring must | {01620}                                                                |                                                                                                                          |                          |                                                                 |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                        |                                                                                                                          |                          |                                                                 |
|---------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|-----------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |                          | (X3) DATE SURVEY COMPLETED<br><br><b>R</b><br><b>01/27/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |                          |                                                                 |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                                 |
| {01620}                                                       | Continued From page 9<br><br>be conducted by a registered nurse:<br>(1) no more than 14 calendar days after initiation of services;<br>(2) as needed based on changes in the resident's needs; and<br>(3) at least every 90 calendar days.<br>(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.<br>(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.<br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Not reviewed during this survey. | {01620}                                                                |                                                                                                                          |                          |                                                                 |
| {01640}<br>SS=E                                               | 144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to<br><br>(a) No later than 14 calendar days after the date that services are first provided, an assisted living                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | {01640}                                                                |                                                                                                                          |                          |                                                                 |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                        |                                                                                                                          |                          |                                                                 |
|---------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|-----------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |                          | (X3) DATE SURVEY COMPLETED<br><br><b>R</b><br><b>01/27/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |                          |                                                                 |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                                 |
| {01640}                                                       | Continued From page 10<br><br>facility shall finalize a current written service plan.<br>(b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities.<br>(c) The facility must implement and provide all services required by the current service plan.<br>(d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable.<br>(e) Staff providing services must be informed of the current written service plan.<br><br>This MN Requirement is not met as evidenced by: | {01640}                                                                | Not reviewed during this survey.                                                                                         |                          |                                                                 |
| {01760}<br>SS=D                                               | 144G.71 Subd. 8 Documentation of administration of medication<br><br>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                                                                                                                                                                                                                                                                                                                                                                                                                                                    | {01760}                                                                |                                                                                                                          |                          |                                                                 |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                         |                                                                           |                                                                                                                          |                          |                                                                    |
|---------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION           |                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>01/27/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                         |                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                                    |
| {01760}                                                       | Continued From page 11<br><br>the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan.<br><br>This MN Requirement is not met as evidenced by:                                                                                                          | {01760}                                                                   | Not reviewed during this survey.                                                                                         |                          |                                                                    |
| {01770}<br>SS=F                                               | 144G.71 Subd. 9 Documentation of medication setup<br><br>Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup.<br><br>This MN Requirement is not met as evidenced by:  | {01770}                                                                   |                                                                                                                          |                          |                                                                    |
| {01880}<br>SS=F                                               | 144G.71 Subd. 19 Storage of medications<br><br>An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access.<br><br>This MN Requirement is not met as evidenced by: | {01880}                                                                   |                                                                                                                          |                          |                                                                    |
| {01890}<br>SS=D                                               | 144G.71 Subd. 20 Prescription drugs<br><br>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                                                                                                                                           | {01890}                                                                   |                                                                                                                          |                          |                                                                    |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                         |                                                                                                                          |                          |                                                                    |
|---------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>20147</b>               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>01/27/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b> |                                                                                                                          |                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                                    |
| {01890}                                                       | Continued From page 12<br><br>by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug.<br><br>This MN Requirement is not met as evidenced by:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | {01890}                                                                                 | Not reviewed during this survey.                                                                                         |                          |                                                                    |
| {01950}<br>SS=E                                               | 144G.72 Subd. 4 Administration of treatments and therapy<br><br>Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has:<br>(1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures;<br>(2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and<br><br>This MN Requirement is not met as evidenced by: | {01950}                                                                                 |                                                                                                                          |                          |                                                                    |
| {01960}<br>SS=D                                               | 144G.72 Subd. 5 Documentation of administration of treatments                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | {01960}                                                                                 |                                                                                                                          |                          |                                                                    |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                         |                                                                                                                          |                          |                                                                    |
|---------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>20147</b>               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>01/27/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b> |                                                                                                                          |                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                                    |
| {01960}                                                       | Continued From page 13<br><br>Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs.<br><br>This MN Requirement is not met as evidenced by: | {01960}                                                                                 | Not reviewed during this survey.                                                                                         |                          |                                                                    |
| {01970}<br>SS=D                                               | 144G.72 Subd. 6 Treatment and therapy orders<br><br>There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months.<br><br>This MN Requirement is not met as evidenced by:                                                        | {01970}                                                                                 |                                                                                                                          |                          |                                                                    |
| {02040}<br>SS=E                                               | 144G.81 Subdivision 1 Fire protection and physical environment<br><br>An assisted living facility with dementia care must meet the requirements of section 144G.45 and the following additional requirements:<br>(1) an assessment of safety risks must be                                                                                                                                                                                                                                                                                                                                 | {02040}                                                                                 |                                                                                                                          |                          |                                                                    |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                         |                                                                                                                          |                          |                                                                 |
|---------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|-----------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b>                  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |                          | (X3) DATE SURVEY COMPLETED<br><br><b>R</b><br><b>01/27/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b> |                                                                                                                          |                          |                                                                 |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                                 |
| {02040}                                                       | Continued From page 14<br><br>performed on and around the property. The safety risks identified by the facility on the assessment must be mitigated to protect the residents from harm. The mitigation efforts must be documented in the facility's records; and<br>(2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029.<br><br>This MN Requirement is not met as evidenced by:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | {02040}                                                                                 | Not reviewed during this survey.                                                                                         |                          |                                                                 |
| {02170}<br>SS=E                                               | <b>144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA</b><br><br>(b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following:<br>(1) past and current interests;<br>(2) current abilities and skills;<br>(3) emotional and social needs and patterns;<br>(4) physical abilities and limitations;<br>(5) adaptations necessary for the resident to participate; and<br>(6) identification of activities for behavioral interventions.<br>(c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs.<br>(d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not | {02170}                                                                                 |                                                                                                                          |                          |                                                                 |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                           |                                                                                                                          |                          |                                                                    |
|---------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>01/27/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                                    |
| {02170}                                                       | <p>Continued From page 15</p> <p>limited to:<br/>(1) occupation or chore related tasks;<br/>(2) scheduled and planned events such as entertainment or outings;<br/>(3) spontaneous activities for enjoyment or those that may help defuse a behavior;<br/>(4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music;<br/>(5) spiritual, creative, and intellectual activities;<br/>(6) sensory stimulation activities;<br/>(7) physical activities that enhance or maintain a resident's ability to ambulate or move; and<br/>(8) outdoor activities.</p> <p>This MN Requirement is not met as evidenced by:</p> | {02170}                                                                   | Not reviewed during this survey.                                                                                         |                          |                                                                    |





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

Electronically Delivered

November 6, 2025

Licensee  
Adith Miller Manor  
885 Mankato Avenue  
Winona, MN 55987

RE: Project Number(s) SL20147016

Dear Licensee:

On October 21, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on July 24, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the July 24, 2025 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on July 24, 2025, found not corrected at the time of the October 21, 2025, follow-up survey and/or subject to penalty assessment are as follows:

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

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

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

**DOCUMENTATION OF ACTION TO COMPLY**

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

**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:

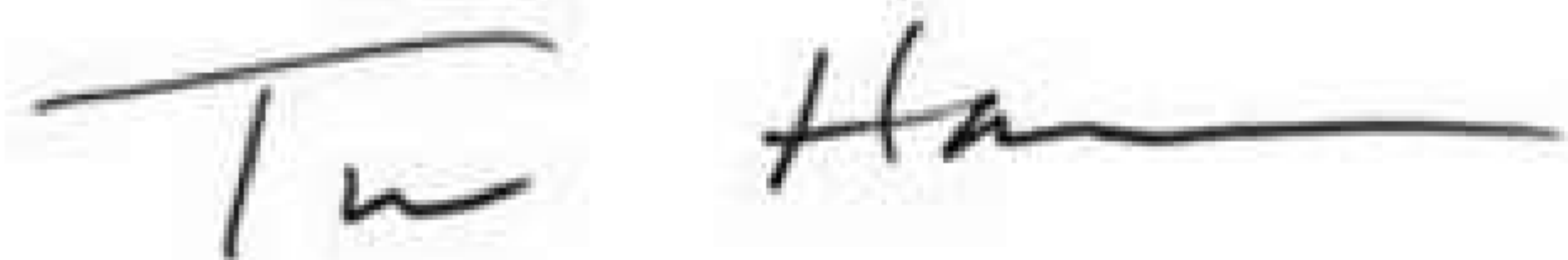
**<https://forms.web.health.state.mn.us/form/HRDAppealsForm>**



We urge you to review these orders carefully. If you have questions, please contact Tim Hanna at 507-208-8982 .

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

Sincerely,

A handwritten signature in black ink, appearing to read "Tim Hanna", is written over a light gray rectangular background.

Tim Hanna, Supervisor  
State Evaluation Team  
Email: [Tim.Hanna@state.mn.us](mailto:Tim.Hanna@state.mn.us)  
Telephone: 507-208-8982 Fax: 1-866-890-9290

HHH



Minnesota Department of Health

|                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                 |                                                                                                                          |                          |                                                   |
|--------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|---------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>20147                 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |                          | (X3) DATE SURVEY COMPLETED<br><br>R<br>10/21/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>ADITH MILLER MANOR |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br>885 MANKATO AVENUE<br>WINONA, MN 55987 |                                                                                                                          |                          |                                                   |
| (X4) ID<br>PREFIX<br>TAG                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                   |
| {0 000}                                                | Initial Comments<br><br>*****ATTENTION*****<br><br>ASSISTED LIVING PROVIDER FOLLOW UP<br>SURVEY<br><br>INITIAL COMMENTS<br><br>SL20417016-1<br><br>On October 20, 2025, and October 21, 2025, the<br>Minnesota Department of Health conducted a<br>follow-up survey at the above provider to<br>follow-up on orders issued pursuant to a survey<br>completed on July 21, 2025. As a result of the<br>follow-up survey, the following order was<br>reissued.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | {0 000}                                                                         |                                                                                                                          |                          |                                                   |
| {0 480}<br>SS=F                                        | 144G.41 Subdivision 1 Subd. 1a (a-b) Minimum<br>requirements; required food services<br><br>(a) Except as provided in paragraph (b), food<br>must be prepared and served according to the<br>Minnesota Food Code, Minnesota Rules, chapter<br>4626.<br>(b) For an assisted living facility with a licensed<br>capacity of ten or fewer residents:<br>(1) notwithstanding Minnesota Rules, part<br>4626.0033, item A, the facility may share a<br>certified food protection manager (CFPM) with<br>one other facility located within a 60-mile radius<br>and under common management provided the<br>CFPM is present at each facility frequently<br>enough to effectively administer, manage, and<br>supervise each facility's food service operation;<br>(2) notwithstanding Minnesota Rules, part<br>4626.0545, item A, kick plates that are not<br>removable or cannot be rotated open are allowed<br>unless the facility has been issued repeated | {0 480}                                                                         |                                                                                                                          |                          |                                                   |

Minnesota Department of Health

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

TITLE

(X6) DATE



Minnesota Department of Health  
STATE FORM 6899 LHK12 If continuation sheet 2 of 15



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                         |                                                                                                                          |  |                                                                    |
|---------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>20147</b>               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>10/21/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {0 630}                                                       | Continued From page 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | {0 630}                                                                                 | Not reviewed during this survey.                                                                                         |  |                                                                    |
| {0 630}<br>SS=E                                               | 144G.42 Subd. 6 (b) Compliance with requirements for reporting ma<br><br>(b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse.<br><br>This MN Requirement is not met as evidenced by:                           | {0 630}                                                                                 |                                                                                                                          |  |                                                                    |
| {0 775}<br>SS=E                                               | 144G.45 Subd. 2. (a) Fire protection and physical environment<br><br>Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:<br><br>This MN Requirement is not met as evidenced by:<br>Based on record review and interview, the licensee failed to comply with the requirements of Minnesota State Fire Code Rules, Chapter 7511.<br><br>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 | {0 775}                                                                                 |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                         |                                                                                                                          |  |                                                                 |
|---------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b>                  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>R</b><br><b>10/21/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b> |                                                                                                                          |  |                                                                 |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                        |
| {0 775}                                                       | <p>Continued From page 3</p> <p>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>On October 20, 2025, the surveyor emailed the licensee and requested a plan of correction for the 0775 tag.</p> <p>On October 21, 2025, licensed assisted living director /registered nurse (LALD/RN)-A responded:</p> <p>1. All staff were given a key (with the med cart keys and for the RN) to the courtyard area at last day of survey. We actually had a key, but staff were unaware, so re-education was provided. This was in effect until the combination lock was available.</p> <p>2. The week of September 15, 2025 (note we did not get the survey enforcement package until September 15, 2025), the facilities director (FD)-D contacted two contractors for bids on running the fire alarm lines/unlocks. The invoice for the accepted bid was dated September 17, 2025, and this contractor has been selected to complete the installations.</p> <p>Previous survey findings:</p> <p>On July 23, 2025, at 10:05 a.m., the surveyor toured the facility with facilities director (FD)-D, master plumber (MP)-K, and administrative assistant (AA)-L. During the facility tour, the surveyor observed the following:</p> <p><b>CONTROLLED EGRESS DOOR LOCKING SYSTEM</b></p> <p>- Electromagnetic locks were installed on the</p> | {0 775}                                                                                 |                                                                                                                          |  |                                                                 |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                         |                                                                                                                          |  |                                                                    |
|---------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>20147</b>               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>10/21/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {0 775}                                                       | <p>Continued From page 4</p> <p>emergency exit doors. Keypads were installed at these doors and required entry of a code into the keypad to unlock. A switch or device was not installed at the nurse station or other approved location that had the capability to break power to all locked doors. During the facility tour interview, FD-D verified the above listed locking observations. Controlled egress door locking systems must comply with Minnesota State Fire Code Rules, Chapter 7511.</p> <p>- On July 23, 2025, licensed assisted living director/registered nurse (LALD/RN)-A and AA-L provided emergency plan documents. Record review indicated the emergency plan did not include procedures to operate and unlock the controlled egress door locking system. During an interview on July 23, 2025, at 12:50 p.m., LALD/RN-A verified these instructions were not included in the emergency plan.</p> <p><b>OBSTRUCTED EXITING</b><br/>The shared exterior courtyard for both assisted living buildings was enclosed by a fence. In the Adith Miller building, an illuminated exit sign was installed above the door exiting into this courtyard. A lock requiring a key to unlock was installed on the gate leading to the public way. During the facility tour interview, FD-D stated maintenance staff had keys to open the lock and were unsure which other employees had keys. FD-D verified the above listed observations. Gate locking that is part of the egress path must comply with Minnesota State Fire Code Rules, Chapter 7511.</p> | {0 775}                                                                                 |                                                                                                                          |  |                                                                    |
| {0 780}<br>SS=E                                               | <p><b>144G.45 Subd. 2 (a) (1) Fire protection and physical environment</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | {0 780}                                                                                 |                                                                                                                          |  |                                                                    |



Minnesota Department of Health  
STATE FORM 6899 LHK12 If continuation sheet 6 of 15



Minnesota Department of Health  
STATE FORM 6899 LHK12 If continuation sheet 7 of 15



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                         |                                                                                                                          |  |                                                                 |
|---------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b>                  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>R</b><br><b>10/21/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b> |                                                                                                                          |  |                                                                 |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                        |
| {01290}                                                       | Continued From page 7<br><br>(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.<br>(b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12.<br>(c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits.<br><br>This MN Requirement is not met as evidenced by: | {01290}                                                                                 | Not reviewed during this survey.                                                                                         |  |                                                                 |
| {01620}<br>SS=D                                               | 144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring<br><br>(a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment.<br>(b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods                                  | {01620}                                                                                 |                                                                                                                          |  |                                                                 |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                        |                                                                                                                          |                          |                                                                 |
|---------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|-----------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |                          | (X3) DATE SURVEY COMPLETED<br><br><b>R</b><br><b>10/21/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |                          |                                                                 |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                                 |
| {01620}                                                       | <p>Continued From page 8</p> <p>based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery.</p> <p>(c) Resident reassessment and monitoring must be conducted by a registered nurse:</p> <p>(1) no more than 14 calendar days after initiation of services;</p> <p>(2) as needed based on changes in the resident's needs; and</p> <p>(3) at least every 90 calendar days.</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by:</p> | {01620}                                                                | Not reviewed during this survey.                                                                                         |                          |                                                                 |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                         |                                                                                                                          |  |                                                                 |
|---------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b>                  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>R</b><br><b>10/21/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b> |                                                                                                                          |  |                                                                 |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                        |
| {01640}                                                       | Continued From page 9                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | {01640}                                                                                 |                                                                                                                          |  |                                                                 |
| {01640}<br>SS=E                                               | <p><b>144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to</b></p> <p>(a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan.</p> <p>(b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities.</p> <p>(c) The facility must implement and provide all services required by the current service plan.</p> <p>(d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable.</p> <p>(e) Staff providing services must be informed of the current written service plan.</p> <p>This MN Requirement is not met as evidenced by:</p> | {01640}                                                                                 |                                                                                                                          |  |                                                                 |
| {01760}<br>SS=D                                               | <p><b>144G.71 Subd. 8 Documentation of administration of medication</b></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</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | {01760}                                                                                 | Not reviewed during this survey.                                                                                         |  |                                                                 |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                        |                                                                                                                          |                          |                                                                 |
|---------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|-----------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |                          | (X3) DATE SURVEY COMPLETED<br><br><b>R</b><br><b>10/21/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |                          |                                                                 |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                                 |
| {01760}                                                       | Continued From page 10<br><br>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.<br><br>This MN Requirement is not met as evidenced by: | {01760}                                                                | Not reviewed during this survey.                                                                                         |                          |                                                                 |
| {01770}<br>SS=F                                               | 144G.71 Subd. 9 Documentation of medication setup<br><br>Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup.<br><br>This MN Requirement is not met as evidenced by:                                                                                                                                                                         | {01770}                                                                |                                                                                                                          |                          |                                                                 |
| {01880}<br>SS=F                                               | 144G.71 Subd. 19 Storage of medications<br><br>An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access.<br><br>This MN Requirement is not met as evidenced by:                                                                                                                                                                        | {01880}                                                                |                                                                                                                          |                          |                                                                 |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                         |                                                                                                                          |  |                                                                    |
|---------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>20147</b>               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>10/21/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {01890}<br>SS=D                                               | <b>144G.71 Subd. 20 Prescription drugs</b><br><br>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.<br><br>This MN Requirement is not met as evidenced by:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | {01890}                                                                                 | Not reviewed during this survey.                                                                                         |  |                                                                    |
| {01950}<br>SS=E                                               | <b>144G.72 Subd. 4 Administration of treatments and therapy</b><br><br>Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has:<br>(1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures;<br>(2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and<br><br>This MN Requirement is not met as evidenced by: | {01950}                                                                                 |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                         |                                                                                                                          |                          |                                                                    |
|---------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>20147</b>               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>10/21/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b> |                                                                                                                          |                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                                    |
| {01960}<br>SS=D                                               | <b>144G.72 Subd. 5 Documentation of<br/>administration of treatments</b><br><br>Each treatment or therapy administered by an<br>assisted living facility must be in the resident<br>record. The documentation must include the<br>signature and title of the person who<br>administered the treatment or therapy and must<br>include the date and time of administration.<br>When treatment or therapies are not<br>administered as ordered or prescribed, the<br>provider must document the reason why it was<br>not administered and any follow-up procedures<br>that were provided to meet the resident's needs.<br><br>This MN Requirement is not met as evidenced<br>by: | {01960}                                                                                 | Not reviewed during this survey.                                                                                         |                          |                                                                    |
| {01970}<br>SS=D                                               | <b>144G.72 Subd. 6 Treatment and therapy orders</b><br><br>There must be an up-to-date written or<br>electronically recorded order from an authorized<br>prescriber for all treatments and therapies. The<br>order must contain the name of the resident, a<br>description of the treatment or therapy to be<br>provided, and the frequency, duration, and other<br>information needed to administer the treatment or<br>therapy. Treatment and therapy orders must be<br>renewed at least every 12 months.<br><br>This MN Requirement is not met as evidenced<br>by:                                                                                                         | {01970}                                                                                 |                                                                                                                          |                          |                                                                    |
| {02040}<br>SS=E                                               | <b>144G.81 Subdivision 1 Fire protection and<br/>physical environment</b><br><br>An assisted living facility with dementia care must                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | {02040}                                                                                 | Not reviewed during this survey.                                                                                         |                          |                                                                    |
|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                         |                                                                                                                          |                          |                                                                    |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                         |                                                                                                                          |                          |                                                                 |
|---------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|-----------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b>                  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |                          | (X3) DATE SURVEY COMPLETED<br><br><b>R</b><br><b>10/21/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b> |                                                                                                                          |                          |                                                                 |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                                 |
| {02040}                                                       | Continued From page 13<br><br>meet the requirements of section 144G.45 and the following additional requirements:<br>(1) an assessment of safety risks must be performed on and around the property. The safety risks identified by the facility on the assessment must be mitigated to protect the residents from harm. The mitigation efforts must be documented in the facility's records; and<br>(2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029.<br><br>This MN Requirement is not met as evidenced by:                                                                                                                                                                                                                           | {02040}                                                                                 | Not reviewed during this survey.                                                                                         |                          |                                                                 |
| {02170}<br>SS=E                                               | <b>144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA</b><br><br>(b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following:<br>(1) past and current interests;<br>(2) current abilities and skills;<br>(3) emotional and social needs and patterns;<br>(4) physical abilities and limitations;<br>(5) adaptations necessary for the resident to participate; and<br>(6) identification of activities for behavioral interventions.<br>(c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs.<br>(d) A selection of daily structured and non-structured activities must be provided and | {02170}                                                                                 |                                                                                                                          |                          |                                                                 |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                           |                                                                                                                          |                          |                                                                    |
|---------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>10/21/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                                    |
| {02170}                                                       | <p>Continued From page 14</p> <p>included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to:</p> <ul style="list-style-type: none"><li>(1) occupation or chore related tasks;</li><li>(2) scheduled and planned events such as entertainment or outings;</li><li>(3) spontaneous activities for enjoyment or those that may help defuse a behavior;</li><li>(4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music;</li><li>(5) spiritual, creative, and intellectual activities;</li><li>(6) sensory stimulation activities;</li><li>(7) physical activities that enhance or maintain a resident's ability to ambulate or move; and</li><li>(8) outdoor activities.</li></ul> <p>This MN Requirement is not met as evidenced by:</p> | {02170}                                                                   | <p>Not reviewed during this survey.</p>                                                                                  |                          |                                                                    |





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

Electronically Delivered

September 15, 2025

Licensee  
Adith Miller Manor  
885 Mankato Avenue  
Winona, MN 55987

RE: Project Number SL20147016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 24, 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 . . ."

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

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

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

The correction order documentation should include the following:

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



### **CORRECTION ORDER RECONSIDERATION PROCESS**

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

To submit a reconsideration request, please visit:

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

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:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/24/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 000                                                         | <p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER LICENSING<br/>CORRECTION ORDER(S)</p> <p>In accordance with Minnesota Statutes, section<br/>144G.08 to 144G.95, these correction orders are<br/>issued pursuant to a survey.</p> <p>Determination of whether violations are corrected<br/>requires compliance with all requirements<br/>provided at the Statute number indicated below.<br/>When Minnesota Statute contains several items,<br/>failure to comply with any of the items will be<br/>considered lack of compliance.</p> <p>INITIAL COMMENTS:</p> <p>SL20147016-0</p> <p>On July 21, 2025, through July 24, 2025, the<br/>Minnesota Department of Health conducted a full<br/>survey at the above provider and the following<br/>correction orders are issued. At the time of the<br/>survey, there were 19 residents; 19 receiving<br/>services under the Assisted Living Facility with<br/>Dementia Care license.</p> | 0 000                                                                  | <p>Minnesota Department of Health is<br/>documenting the State Correction Orders<br/>using federal software. Tag numbers have<br/>been assigned to Minnesota State<br/>Statutes for Assisted Living Facilities. The<br/>assigned tag number appears in the<br/>far-left column entitled "ID Prefix Tag." The<br/>state Statute number and the<br/>corresponding text of the state Statute out<br/>of compliance is listed in the "Summary<br/>Statement of Deficiencies" column. This<br/>column also includes the findings which<br/>are in violation of the state requirement<br/>after the statement, "This Minnesota<br/>requirement is not met as evidenced by."<br/>Following the evaluators ' findings is the<br/>Time Period for Correction.</p> <p>PLEASE DISREGARD THE HEADING OF<br/>THE FOURTH COLUMN WHICH<br/>STATES,"PROVIDER'S PLAN OF<br/>CORRECTION." THIS APPLIES TO<br/>FEDERAL DEFICIENCIES ONLY. THIS<br/>WILL APPEAR ON EACH PAGE.</p> <p>THERE IS NO REQUIREMENT TO<br/>SUBMIT A PLAN OF CORRECTION FOR<br/>VIOLATIONS OF MINNESOTA STATE<br/>STATUTES.</p> <p>THE LETTER IN THE LEFT COLUMN IS<br/>USED FOR TRACKING PURPOSES AND<br/>REFLECTS THE SCOPE AND LEVEL<br/>ISSUED PURSUANT TO 144G.31<br/>SUBDIVISION 1-3.</p> |  |                                                     |
| 0 480<br>SS=F                                                 | 144G.41 Subdivision 1 Subd. 1a (a-b) Minimum<br>requirements; required food services                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 0 480                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                     |

Minnesota Department of Health

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

TITLE

(X6) DATE



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/24/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 480                                                         | Continued From page 1<br><br>(a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626.<br>(b) For an assisted living facility with a licensed capacity of ten or fewer residents:<br>(1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation;<br>(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;<br>(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;<br>(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;<br>(5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are | 0 480                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                         |                                                                                                                          |  |                                                        |
|---------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>20147</b>               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/24/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 0 480                                                         | <p>Continued From page 2</p> <p>allowed provided the facility keeps them clean and in good condition;<br/>(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<br/>(7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door.</p> <p>This MN Requirement is not met as evidenced by:<br/>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, 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).</p> <p>The findings include:</p> <p>Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated, July 22, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.</p> | 0 480                                                                                   |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/24/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 480                                                         | Continued From page 3                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 0 480                                                                  |                                                                                                                          |  |                                                     |
|                                                               | TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                        |                                                                                                                          |  |                                                     |
| 0 630<br>SS=E                                                 | <p>144G.42 Subd. 6 (b) Compliance with requirements for reporting ma</p> <p>(b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for two of two residents (R5, R7).</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> | 0 630                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/24/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 630                                                         | <p>Continued From page 4</p> <p>R5<br/>R5's diagnoses included Alzheimer's disease.</p> <p>R5's Service Plan dated September 18, 2024, included the services of medication management/administration, assistance with bathing, dressing, grooming, meals and housekeeping. R5's Service Plan lacked the service of wound care management.</p> <p>On July 22, 2025, at 6:20 a.m., the surveyor observed unlicensed personnel (ULP)-I assisting R5 in the bathroom during morning cares and brushing teeth.</p> <p>R5's IAPP dated September 18, 2024, indicated "Yes" responses to the following areas of vulnerability:</p> <ul style="list-style-type: none"><li>- Orientation to time, place and person, with intervention "living in memory care with 24/7 support";</li><li>- ability to give accurate information, with intervention "staff and family provide assistance";</li><li>- able to ambulate safely with/without assistive devices; safe use of assistive devices with intervention "uses 4 wheeled walker";</li><li>- use of telephone with intervention "staff/family assist";</li><li>- management of personal finances with intervention "family manages";</li><li>- able to report abuse or neglect, with intervention "staff and family provide oversight and safety; and</li><li>- behaviors posing a risk to self, with intervention "lives in a locked memory care facility".</li></ul> <p>R5's IAPP also included the statement, "Resident does not appear to pose a threat to other vulnerable adults". The licensee did not include a check mark with this statement, thus indicating</p> | 0 630                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/24/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 630                                                         | <p>Continued From page 5</p> <p>R5 was susceptible to abusing others, including other vulnerable adults.</p> <p>On July 23, 2025, at 2:15 p.m. clinical nurse supervisor (CNS)-B stated the licensee had switched to a new electronic medical record system earlier this year and some of the formatting has been confusing to the nurses. After further review of R5's IAPP as completed, CNS-B stated the content of R5's IAPP had inconsistencies and inaccurate selections. She stated R5 was a vulnerable adult and was susceptible to abuse by others, including other vulnerable adults and R5's IAPP did not clearly indicate this. CNS-B further stated R5 was not susceptible to abusing others including other vulnerable adults and his IAPP did not accurately depict this.</p> <p>R7<br/>R7's diagnoses included late onset Alzheimer's dementia, hypertension and history of pulmonary embolism (blood clot in the lungs).</p> <p>R7's Service Plan dated February 4, 2025, included the services of medication management/administration, compression stockings, and assistance with bathing, dressing, grooming, and housekeeping.</p> <p>On July 22, 2025, at 7:58 a.m., the surveyor observed ULP-G set up and administer R7's medications at the dining room table.</p> <p>R7's IAPP dated January 31, 2025, indicated R7 was vulnerable in managing her personal finances and had a power of attorney (POA), and further indicated she was vulnerable to consistently follow directions and was in a 24-hour care facility.</p> | 0 630                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                         |                                                                                                                          |  |                                                        |
|---------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>20147</b>               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/24/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 0 630                                                         | <p>Continued From page 6</p> <p>R7's IAPP also included a section indicating "check the appropriate statements" which included the following statement: "The resident does not appear to pose a threat to other vulnerable adults". This statement was not selected/checked by the licensee indicating R7 was susceptible to abusing others including other vulnerable adults.</p> <p>On July 24, 2025, at 12:30 p.m., CNS-B indicated R7's IAPP had inconsistencies in how it was completed. R7's IAPP did not clearly indicate she was susceptible to abuse by others including other vulnerable adults and further stated R7 was not at risk to abuse others; however, R7's IAPP appeared to indicate she was susceptible to abuse others, including other vulnerable adults. CNS-B stated she needed to further educate the nurses in accurate completion of the IAPP format being used and ensure there were clear indications of susceptibility to abuse and susceptibility to abusing others.</p> <p>The licensee failed to clearly and accurately depict R5 and R7's susceptibility to abuse by others including other vulnerable adults and their susceptibility to abusing others including other vulnerable adults.</p> <p>The licensee's Vulnerable Adult Reporting and Investigation policy dated February 2024, indicated each resident receiving nursing services will have a written individualized abuse prevention plan. The plan will contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including:</p> <p>a. Resident's potential to abuse another individual/vulnerable adult;</p> | 0 630                                                                                   |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/24/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 630                                                         | Continued From page 7<br><br>b. Resident's risk if abuse from other vulnerable adults, others or themselves; and<br>c. interventions to minimize the risk of abuse to the resident and other vulnerable adults.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 0 630                                                                  |                                                                                                                          |  |                                                     |
| 0 775<br>SS=E                                                 | 144G.45 Subd. 2. (a) Fire protection and physical environment<br><br>Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to comply with the requirements of Minnesota State Fire Code Rules, Chapter 7511.<br><br>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).<br><br>The findings include:<br><br>On July 23, 2025, at 10:05 a.m., the surveyor toured the facility with facilities director (FD)-D, master plumber (MP)-K, and administrative | 0 775                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/24/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 775                                                         | <p>Continued From page 8</p> <p>assistant (AA)-L. During the facility tour, the surveyor observed the following:</p> <p><b>CONTROLLED EGRESS DOOR LOCKING SYSTEM</b></p> <p>- Electromagnetic locks were installed on the emergency exit doors. Keypads were installed at these doors and required entry of a code into the keypad to unlock. A switch or device was not installed at the nurse station or other approved location that had the capability to break power to all locked doors. During the facility tour interview, FD-D verified the above listed locking observations. Controlled egress door locking systems must comply with Minnesota State Fire Code Rules, Chapter 7511.</p> <p>- On July 23, 2025, licensed assisted living director/registered nurse (LALD/RN)-A and AA-L provided emergency plan documents. Record review indicated the emergency plan did not include procedures to operate and unlock the controlled egress door locking system. During an interview on July 23, 2025, at 12:50 p.m., LALD/RN-A verified these instructions were not included in the emergency plan.</p> <p><b>OBSTRUCTED EXITING</b></p> <p>The shared exterior courtyard for both assisted living buildings was enclosed by a fence. In the Adith Miller building, an illuminated exit sign was installed above the door exiting into this courtyard. A lock requiring a key to unlock was installed on the gate leading to the public way. During the facility tour interview, FD-D stated maintenance staff had keys to open the lock and were unsure which other employees had keys. FD-D verified the above listed observations. Gate locking that is part of the egress path must comply with Minnesota State Fire Code Rules,</p> | 0 775                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/24/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 775                                                         | Continued From page 9<br><br>Chapter 7511.<br><br>CARBON MONOXIDE<br>There were carbon monoxide alarms installed in the corridors in several locations in the Adith Miller and Roger Metz buildings. Carbon monoxide alarms were not installed outside and within ten feet of all sleeping rooms. FD-D stated during the tour that the existing carbon monoxide alarms were not tied into the building fire alarm system and verified the above listed observations.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days                                                                                                                                                                                                                                                                                                                                | 0 775                                                                  |                                                                                                                          |  |                                                     |
| 0 780<br>SS=E                                                 | 144G.45 Subd. 2 (a) (1) Fire protection and physical environment<br><br>(a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:<br>(1) for dwellings or sleeping units, as defined in the State Fire Code:<br>(i) provide smoke alarms in each room used for sleeping purposes;<br>(ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms;<br>(iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics;<br>(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 | 0 780                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/24/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 780                                                         | <p>Continued From page 10</p> <p>(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;</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation and interview, the licensee failed to provide smoke alarms that complied with fire protection requirements.<br/>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).<br/>The findings include:<br/>On July 23, 2025, at 10:05 a.m., the surveyor toured the facility with facilities director (FD)-D, master plumber (MP)-K, and administrative assistant (AA)-L. During the facility tour, the surveyor observed the following:<br/>Adith Miller Building:<br/>Smoke detectors were installed outside resident sleeping rooms. Smoke alarms were not installed outside and in the immediate vicinity of all resident sleeping rooms.</p> <p>Roger Metz Building:<br/>When smoke alarms in resident sleeping rooms and outside the resident rooms were tested by</p> | 0 780                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/24/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 780                                                         | Continued From page 11<br><br>FD-D, the other dwelling unit smoke alarms were not actuated.<br><br>During the facility tour interview, FD-D verified the above listed smoke alarm observations. Smoke alarms must be installed outside and within 21 feet of each sleeping room. All dwelling unit smoke alarms must be interconnected so actuation of one alarm causes all alarms in the dwelling unit to operate.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days                                                                                                                                                                                                                                                                                                                                                                                                                    | 0 780                                                                  |                                                                                                                          |  |                                                     |
| 0 810<br>SS=F                                                 | 144G.45 Subd. 2 (b-f) Fire protection and physical environment<br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:<br>(1) location and number of resident sleeping rooms;<br>(2) staff actions to be taken in the event of a fire or similar emergency;<br>(3) fire protection procedures necessary for residents; and<br>(4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation.<br>(c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter.<br>(d) Fire safety and evacuation plans shall be readily available at all times within the facility. | 0 810                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/24/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 810                                                         | <p>Continued From page 12</p> <p>(e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year.</p> <p>(f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with required content, make all parts of the plan readily available, and provide required training. This had the potential to directly affect all residents, staff, and visitors.</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 potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>On July 23, 2025, licensed assisted living director/registered nurse (LALD/RN)-A, facilities director (FD)-D, and administrative assistant (AA)-L provided documents on the fire safety and evacuation plan (FSEP), fire safety and</p> | 0 810                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/24/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 810                                                         | <p>Continued From page 13</p> <p>evacuation training, and evacuation drills for the facility.</p> <p><b>FIRE SAFETY AND EVACUATION PLAN</b><br/>The FSEP failed to identify the number of resident sleeping rooms and the emergency exit doors for the buildings evident by a review of the facility floor plans.<br/>On July 23, 2025, at 10:05 a.m., the surveyor toured the facility with FD-D, master plumber (MP)-K, and AA-L. During the facility tour, the surveyor observed the following:</p> <ul style="list-style-type: none"><li>- Floor plans were posted in common areas of the buildings. Numbers were posted at the door for each resident room. Record review of the available documentation indicated the licensee failed to identify the resident sleeping rooms by number on the posted FSEP floor plans. Resident room number labels are required to be included on the FSEP floor plan to provide efficient communication for exiting in the event of a fire or similar emergency.</li><li>- The FSEP floor plans posted in the common areas failed to identify the location of the emergency exit doors for the facility. Red arrows were used indicating exit routes but exit doors were not labeled.</li><li>- The windows in resident sleeping room were inappropriately labeled as exit routes on the FSEP floor plans. The resident room windows were restricted from opening to provide egress escape.</li></ul> <p>During the facility tour interview, FD-D and AA-L verified the above listed FSEP floor plan observations.</p> <p>The FSEP included campus wide employee procedures, but failed to provide site specific employee actions to take in the event of a fire or</p> | 0 810                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/24/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 810                                                         | <p>Continued From page 14</p> <p>similar emergency relative to each assisted living building.</p> <p>The FSEP included campus wide resident evacuation procedures, but failed to provide site specific procedures for resident movement and evacuation or relocation from each assisted living building during a fire or similar emergency including individualized unique needs of residents. Record review indicated the FSEP did not include evacuation procedures for the individualized unique needs of residents. During an interview on July 23, 2025, at 12:50 p.m., LALD/RN-A stated residents requiring staff assistance in an emergency had been identified, and these procedures were maintained electronically on the computer. These individualized evacuation procedures were not included with the printed copy of the FSEP. All parts of the FSEP must be maintained as readily available for accessibility.</p> <p>During an interview on July 23, 2025, at 12:50 p.m., LALD/RN-A verified the FSEP required revision.</p> <p><b>TRAINING</b><br/>Record review indicated the licensee failed to provide fire safety and evacuation training to residents at least once per year evident by the lack of documentation to support this training had been completed. During an interview on July 23, 2025, at 12:50 p.m., LALD/RN-A stated resident were trained at the time of admission, and no additional training had been recorded.</p> <p>Record review indicated the licensee failed to provide training to employees on the FSEP at least twice per year evident by the lack of documentation to support FSEP training had</p> | 0 810                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/24/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 810                                                         | Continued From page 15<br><br>been completed. Documentation for a facility policies training dated September 2024 was provided. This employee training documentation did not list FSEP on the agenda. During an interview on July 23, 2025, at 12:50 p.m., LALD/RN-A stated if additional records were located these would be emailed to the surveyor today no later than 4:00 p.m. Documentation to support site specific FSEP employee training was not received.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days                                                                                                                                                                                                                                                                                                                                                                                                                           | 0 810                                                                  |                                                                                                                          |  |                                                     |
| 01290<br>SS=F                                                 | 144G.60 Subdivision 1 Background studies required<br><br>(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.<br>(b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12.<br>(c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure one of 27 | 01290                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/24/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01290                                                         | <p>Continued From page 16</p> <p>employees (unlicensed personnel (ULP)-J) were affiliated with the assisted living license as required. This had the potential to affect all residents residing within the facility.</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>ULP-J was hired on February 15, 2024, to provide direct care services to the licensee's residents.</p> <p>ULP-J's employee record contained a background study dated February 7, 2024, for another health facility identification number (HFID#). ULP-J's record lacked evidence the licensee affiliated ULP-J's background study to their assisted living facility's HFID.</p> <p>On July 23, 2025, at 9:45 a.m., licensed assisted living director/registered nurse (LALD/RN)-A indicated ULP-J was an employee who transferred her work assignment from a "sister" facility (HFID-30797) and had not been affiliated with this licensee's HFID# 20147.</p> <p>On July 24, 2025, at 10:24 a.m., LALD/RN-A provided the surveyor with an updated NETStudy roster indicating ULP-J had now been affiliated with the licensee.</p> <p>The licensee's Background Checks and Workforce Clearance policy dated February 2021,</p> | 01290                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/24/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01290                                                         | <p>Continued From page 17</p> <p>indicated [licensee name] is committed to providing a safe environment by ensuring employees are screened through appropriate background studies. Applicants will be notified of [licensee name] policy and practice of conducting a background investigation before a candidate is hired. There are two separate background studies that may be performed:</p> <p>A. Background study conducted by an independent company, reviewing the following:</p> <ol style="list-style-type: none"><li>1. Criminal records</li><li>2. Social Security Number (SSN) validation</li><li>3. Employment history</li><li>4. Drug screen (see HR-64)</li><li>5. Health care sanctions</li><li>6. National Sex Offender Registry</li></ol> <p>B. Minnesota Department of Human Services (OHS) Net Study 2.0, which includes submission of:</p> <ol style="list-style-type: none"><li>1. Fingerprints</li><li>2. Photograph</li></ol> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Two (2) days</p> | 01290                                                                  |                                                                                                                          |  |                                                     |
| 01620<br>SS=D                                                 | <p>144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring</p> <p>(a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment.</p> <p>(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</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 01620                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/24/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01620                                                         | <p>Continued From page 18</p> <p>which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery.</p> <p>(c) Resident reassessment and monitoring must be conducted by a registered nurse:</p> <p>(1) no more than 14 calendar days after initiation of services;</p> <p>(2) as needed based on changes in the resident's needs; and</p> <p>(3) at least every 90 calendar days.</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> | 01620                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/24/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01620                                                         | <p>Continued From page 19</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed wound assessments/measurements and a 14-day comprehensive RN assessment for one of two residents (R5).</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><b>WOUND ASSESSMENT</b><br/>On July 21, 2025, at 11:30 a.m. during entrance conference, clinical nurse supervisor (CNS)-B stated the licensee only managed simple wounds to the level of first aid response and outsourced more complex wound care to a local home health provider.</p> <p>R5 was admitted to the facility under the Assisted Living with Dementia Care license on September 18, 2024, with diagnoses including Alzheimer's disease.</p> <p>R5's Service Plan dated September 18, 2024, included the services of medication management/administration, assistance with bathing, dressing, grooming and meal preparation. R5's Service Plan lacked the service</p> | 01620                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/24/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01620                                                         | <p>Continued From page 20</p> <p>of wound care.</p> <p>On July 22, 2025, at 6:20 a.m., the surveyor observed unlicensed personnel (ULP)-I assisting R5 with morning cares, brushing teeth and toileting.</p> <p>On July 22, 2025, at 7:00 a.m., ULP-H stated R5 had a left buttock wound dressing that was managed by an outside agency RN. ULP-H stated the ULP were only to replace the dressing as needed if soiled or coming loose. ULP-H stated the home health RN was scheduled to come today to provide wound care and a dressing change.</p> <p>On July 22, 2025, at 9:40 a.m., CNS-B stated [outside agency home health company] RN completed weekly wound care and dressing changes. CNS-B further indicated the home health RN did not communicate with the licensee's RN regarding R5's wound condition or provide measurements. CNS-B stated the licensee's RN had not assessed R5's wound since the home health agency was managing it.</p> <p>On July 22, 2025, at 11:00 a.m. licensed assisted living director/registered nurse (LALD/RN) stated even though R5's wound care management was being managed by an outside agency RN, the licensee was still responsible to evaluate/assess R5's wound for progress to determine the condition of the wound.</p> <p>On July 22, 2025, at 11:30 a.m., the surveyor met the outside agency home health care RN in the bathroom where she had provided wound care to R5's left upper buttock wound. She stated she used a spray wound cleanser to the wound, pat dried the wound area and placed Opti cell Ag (a</p> | 01620                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/24/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01620                                                         | <p>Continued From page 21</p> <p>special wound packing) inside the wound area and covered with a clear Mepilex border dressing. The home care RN stated the licensee ULP were only to replace the Mepilex border if it was soiled or coming loose; however, the ULP/licensee were not to apply the Opti cell Ag dressing. The home care RN stated she wrote a weekly progress note and wound measurements in her documentation system; however, she did not share notes or measurements with the licensee's RN. She further stated she had been writing in a communication book which served as "an opportunity for me and the staff to communicate back and forth". She stated she had not been writing in the book lately. The home care RN provided the surveyor with wound measurements (width-0.5 centimeters (cm), length- 0.7 cm, and depth- 0.1 cm) and stated the wound "ebbs and flows" in size and had been a chronic wound.</p> <p>R5's comprehensive RN assessments since his admission in September 2024, were requested. Comprehensive RN assessments dated September 19, 2024, November 27, 2024, December 31, 2024, January 2, 2025, March 28, 2025, and June 13, 2025, were provided. The assessments included a section labeled "Skin Conditions" and included the following entries:</p> <ul style="list-style-type: none"><li>- September 19, 2024- No open sores or concerns at this time. Staff will provide daily hygiene, showers, and monitor skin;</li><li>- November 27, 2024- Occasional red and tender skin on buttocks due to incontinence. Staff provide assistance with all personal cares and hygiene;</li><li>- December 31, 2024- Red, patchy, circular rash on bilateral back legs and thighs. New prescription added for Lotrimin. Sore on buttocks is healed and dry/flaky. No other skin concerns;</li><li>- January 10, 2025- WNL [within normal limits],</li></ul> | 01620                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/24/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01620                                                         | <p>Continued From page 22</p> <p>no concerns;<br/>- January 23, 2025- No skin issues reported;<br/>- March 28, 2025- chronic buttock wound, wound care managed by [home health agency name]. Dressing changed by [home health agency name] nurse today.<br/>- June 13, 2025- wound on coccyx (tailbone area) managed by home health, has had this chronically.</p> <p>R5's progress notes for the previous six months were requested. Resident progress notes dated January 29, 2025, through July 10, 2025, were provided. The only entry regarding R5's buttock wound was, dated March 7, 2025, which indicated, "Resident buttocks wound is now open. Applied barrier cream and new Mepilex dressing to open sore. Discussed situation with [home health agency name] nurse who is doing home health wound care. She is planning to see the resident Monday for a recertification of services, and she plans to up his frequency of visits. A POC [plan of care] update will be provided in the care plan regarding wound dressing."</p> <p>R5's record included a wound care order dated February 17, 2025, indicated apply Mepilex pad to coccyx wound on left buttock every two to three days or change if soiled. The order included special instructions, "Change every two to three days or if soiled with stool. Remove and apply new bandage after showers. Apply barrier cream (past) prior to placing new Mepilex dressing. If no Mepilex available, apply barrier cast to wound and clean brief. Wound care to see resident this week to get more supplies."</p> <p>R5's document known as the care plan included a section with wound care updated on March 7, 2025, included the "Problem" pressure</p> | 01620                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/24/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01620                                                         | <p>Continued From page 23</p> <p>ulcer/injury-Stage one pressure ulcer noted on coccyx, with "Approach" indicating the instruction for ULP to cleanse skin during shower with warm soap and water. Pat dry with clean towel. Apply Mepilex border to tailbone. Change on shower days or if soiled. Report signs of infection to nurse (increased size, redness, color, colored drainage).</p> <p>R5's medication administration record (MAR) dated July 2025, indicated cleanse skin during shower with warm soap and water. Pat dry with clean towel. Apply Mepilex border to tailbone. Change on shower days or if soiled. Report signs of infection to nurse (increased sized, redness, odor, colored drainage). The task was assigned once daily on Mondays and Thursdays. The MAR included staff initials indicating completion on July 3, 7, 10, 14, 17, 21, 2025.</p> <p>The licensee's RN failed to include ongoing documentation and routine assessments of R5's left buttock wound including measurements, drainage, or condition of the wound (redness, foul odor, healing/non-healing). Furthermore, with review of various documents (wound care order February 2025, progress note and care plan update March 7, 2025), the surveyor was unable to clearly determine when R5's buttock wound reappeared and when the home health agency-initiated care of the wound.</p> <p>14 DAY COMPREHENSIVE ASSESSMENT<br/>R5's comprehensive assessments since admission (September 18, 2024) were reviewed. The surveyor noted the RN comprehensive assessment labeled as 14-day assessment was completed on November 27, 2024, 69 days after the date he was admitted.</p> | 01620                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/24/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01620                                                         | <p>Continued From page 24</p> <p>The licensee failed to complete R5's 14-day comprehensive RN assessment within the required period.</p> <p>The licensee's Initial and On-going Nursing Assessment of Assisted Living Residents policy dated May 2022, indicated an RN will complete the following comprehensive nursing assessments of the resident's physical, mental, and cognitive needs as required:</p> <ul style="list-style-type: none"><li>a. Pre-Admission Assessment</li><li>b. 14-day assessment: completed up to 14-days after start of services</li><li>c. Ongoing assessment: completed periodically but no less than every 90-days</li><li>d. Change in resident condition</li></ul> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-One (21) days</p> | 01620                                                                  |                                                                                                                          |  |                                                     |
| 01640<br>SS=E                                                 | <p>144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to</p> <p>(a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan.</p> <p>(b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities.</p>            | 01640                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/24/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01640                                                         | <p>Continued From page 25</p> <p>(c) The facility must implement and provide all services required by the current service plan.</p> <p>(d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable.</p> <p>(e) Staff providing services must be informed of the current written service plan.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview, and record review, the licensee failed to ensure a written service plan was revised to reflect the current services provided for two of two residents (R1, R5).</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>R1<br/>R1 was admitted to the Assisted Living Facility with Dementia Care on April 28, 2025, with diagnoses including Alzheimer's dementia with anxiety and depression.</p> <p>R1's Service Plan dated April 28, 2025, indicated she received level 1 memory care services which included assistance with medication administration, bathing, dressing, grooming,</p> | 01640                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/24/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01640                                                         | <p>Continued From page 26</p> <p>transfers and ambulation, and toileting. R1's Service Plan lacked medication set up services.</p> <p>R1's Medication Plan (used as part of the Service Plan) dated April 28, 2025, lacked an indication Medication Set-up was being provided.</p> <p>On July 22, 2025, at 8:10 a.m. during various medication administration observations with unlicensed personnel (ULP)-G, the surveyor observed two med-minders (plastic medication pill boxes for each day of the week) and were labeled for R1. ULP-G stated she had already administered the morning medications for R1. ULP-G stated the nurse set up the medications in the med-minders, the ULP counted the pills in the designated day of the week and counted how many oral medications were listed on the medication administration record (MAR) for that medication pass. She further stated if the number matched, she administered the medications.</p> <p>R1's MAR dated July 2025, included the "order" administer medications from pillboxes, twice daily, with special instructions, "administer pills from two pill boxes. Blue/purple box is for chewable AM/PM medications. Large pill box is for AM/PM pills, Administer from both in AM/PM". The MAR also indicated two PRN (as needed) medications for pain, one scheduled medication for cholesterol, one for depression, two for dementia, one for gastric reflux, one for thyroid, one for sleep, two oral powders for constipation, five supplements, one nasal spray for allergies, and one eye drop for dry eyes.</p> <p>R1's Resident Progress Notes included the following entries by the licensee's nurses:<br/>-June 23, 2025, Resident's medication set up box completed today by RN [registered nurse] for the</p> | 01640                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/24/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01640                                                         | <p>Continued From page 27</p> <p>week;<br/>-June 30, 2025, set up resident's medication in the med (medication) boxes according to current physician orders;<br/>-July 7, 2025, resident returned today from a leave over the weekend. Resident's medication set up boxes filled with current medication orders from PCP [primary care provider];<br/>-July 14, 2025, filled resident's medication set up boxes for the week using current provider medication orders; and<br/>-July 21, 2025, medications set up in residents med box per current provider orders and locked in med cart to be administered by unlicensed staff</p> <p>On July 23, 2025, at 1:15 p.m., clinical nurse supervisor (CNS)-B stated neither R1's Service Plan nor Medication Plan included the service of medication set-up.</p> <p>R5<br/>R5 was admitted to the facility under the Assisted Living with Dementia Care license on September 18, 2024, with diagnoses including Alzheimer's disease.</p> <p>R5's Service Plan dated September 18, 2024, included the services of medication management/administration, assistance with bathing, dressing, grooming and meal preparation. R5's Service Plan lacked the service of wound care.</p> <p>R5's undated, Treatment Plan (used as part of the Service Plan), indicated "No current treatments".</p> <p>On July 22, 2025, at 7:00 a.m., ULP-H stated R5 had a left buttock wound dressing that was managed by an outside agency RN. ULP-H</p> | 01640                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/24/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01640                                                         | <p>Continued From page 28</p> <p>stated the ULP were only to replace the dressing as needed if soiled or coming loose. ULP-H stated the home health RN was scheduled to come today to provide wound care and a dressing change.</p> <p>On July 22, 2025, at 9:40 a.m., CNS-B stated [outside agency home health company] RN completed weekly wound care and dressing changes. She stated the licensee ULP were monitoring R5's Mepilex dressing and replacing it if soiled or loose.</p> <p>On July 22, 2025, at 11:30 a.m., the surveyor met the outside agency home health care RN in the bathroom where she had provided wound care to R5's left upper buttock wound. She stated she used a spray wound cleanser to the wound, pat dried the wound area and placed Opti cell Ag (a special wound packing) inside the wound area and covered with a clear Mepilex border dressing. The home care RN stated the licensee ULP were only to replace the Mepilex border if it was soiled or coming loose; however, the ULP/licensee were not to apply the Opti cell Ag dressing.</p> <p>R5's progress notes for the previous six months were requested. Resident progress notes dated January 29, 2025, through July 10, 2025, were provided. The only entry regarding R5's buttock wound was dated March 7, 2025, which indicated, "Resident buttocks wound is now open. Applied barrier cream and new Mepilex dressing to open sore. Discussed situation with [home health agency name] nurse who is doing home health wound care. She is planning to see the resident Monday for a recertification of services, and she plans to up his frequency of visits. A POC [plan of care] update will be provided in the care plan regarding wound dressing."</p> | 01640                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/24/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01640                                                         | <p>Continued From page 29</p> <p>R5's record included a wound care order dated February 17, 2025, which indicated to apply Mepilex pad to coccyx wound on left buttock every two to three days or change if soiled. The order included special instructions, "Change every two to three days or if soiled with stool. Remove and apply new bandage after showers. Apply barrier cream (past) prior to placing new Mepilex dressing. If no Mepilex available, apply barrier cast to wound and clean brief. wound care to see resident this week to get more supplies."</p> <p>R5's document, known as the care plan, included a section with wound care updated on March 7, 2025, included the "Problem" pressure ulcer/injury-Stage one pressure ulcer noted on coccyx, with "Approach" indicating the instruction for ULP to cleanse skin during shower with warm soap and water. Pat dry with clean towel. Apply Mepilex border to tailbone. Change on shower days or if soiled. Report signs of infection to nurse (increased size, redness, color, colored drainage).</p> <p>R5's medication administration record (MAR) dated July 2025, indicated cleanse skin during shower with warm soap and water. Pat dry with clean towel. Apply Mepilex border to tailbone. Change on shower days or if soiled. Report signs of infection to nurse (increased sized, redness, odor, colored drainage). The task was assigned once daily on Mondays and Thursdays. The MAR included staff initials indicating completion on July 3, 7, 10, 14, 17, 21, 2025.</p> <p>On July 24, 2025, at 12:35 p.m., CNS-B stated the licensee had been "participating in R5's wound care at various levels/frequencies for a long time." She indicated the home health care</p> | 01640                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/24/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01640                                                         | <p>Continued From page 30</p> <p>agency led the wound care and stated the service of wound care was not included on R5's service plan nor his treatment plan, and should have been.</p> <p>The licensee failed to ensure R1's Service Plan was updated to include medication set up services and R5's service plan was updated included the service of wound care as provided by the licensee.</p> <p>The licensee's Contents of the Service Plan policy dated February 2022, indicated service plans and any revisions to services plans will have a signature or other authentication by the facility and by the resident. Other authentication could be emailed confirmation accepting terms of a service agreement or other method deemed appropriate by the assisted living.</p> <ul style="list-style-type: none"><li>- Service plans are reviewed and revised as needed based upon on-going resident assessment.</li><li>- Service plans will include:</li><li>- A description of the services provided</li><li>- Fees for services</li><li>- Frequency of each service according to resident assessment and resident preferences</li></ul> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p> | 01640                                                                  |                                                                                                                          |  |                                                     |
| 01760<br>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</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 01760                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/24/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01760                                                         | <p>Continued From page 31</p> <p>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:<br/>Based on observation, interview, and record review, the licensee failed to ensure medications were administered as ordered for two of seven residents (R6, R7) and failed to ensure prescriber's orders were accurately transcribed for one of seven residents (R7) receiving medication services.</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>MEDICATION ADMINISTRATION<br/>R6<br/>R6 began receiving services under the facility's Assisted Living Facility with Dementia Care license on April 5, 2024, with diagnoses including hypertension.</p> | 01760                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/24/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01760                                                         | <p>Continued From page 32</p> <p>R6's Service Plan/Medication Plan dated April 4, 2025, indicated she received services to include medication administration.</p> <p>R6's prescriber order dated May 29, 2025, indicated diclofenac 1% gel, 4 grams (gm) to right knee and thigh two times daily.</p> <p>On July 22, 2025, at 7:46 a.m., the surveyor observed ULP-H to administer R6's morning medications. ULP-H stated R6 had already received her diclofenac 1% gel when she was getting dressed earlier in the morning. ULP-H stated he usually used about a quarter sized amount on his gloved hand when applying the gel to her knee and hip. ULP-H stated this was how he was trained by nursing and was not aware of the measuring tool found in R6's diclofenac box.</p> <p>R7<br/>R7 began receiving services under the facility's Assisted Living with Dementia Care License on February 1, 2023, with diagnoses including late onset Alzheimer's dementia, hypertension and history of pulmonary embolism (blood clot in the lungs).</p> <p>R7's Service Plan dated February 4, 2025, included the services of medication management/administration.</p> <p>R7's record included an order dated June 17, 2025, for Diclofenac 1% gel, give 4 grams to left knee three times daily.</p> <p>On July 22, 2025, at 7:58 a.m., the surveyor observed ULP-G set up and administer R7's medications at the dining room table. ULP-G stated she had already provided R7's diclofenac</p> | 01760                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/24/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01760                                                         | <p>Continued From page 33</p> <p>1% gel earlier while assisting her with dressing and getting ready for the day. The surveyor asked ULP-G how she dispensed/measured the diclofenac gel, ULP-G stated she squirted some on her gloved finger and applied it. The surveyor observed a measuring tool in R7's diclofenac gel box and showed it to ULP-G. When asked if ULP-G thought she used 4 grams, ULP-G stated, "no, definitely not, and I was not even aware of the measuring tool in there. I'll start using that."</p> <p>TRANSCRIPTION ERROR</p> <p>R7's signed prescriber's orders dated June 4, 2025, indicated albuterol inhaler, give 2 puffs, every six hours as needed (PRN), use with spacer chamber, for shortness of breath or wheezing.</p> <p>R7's medication administration record (MAR) dated July 2025, indicated:<br/>-albuterol sulfate 90 micrograms/actuation inhaler; administer one to two puffs every four hours as needed for shortness of breath or wheezing.</p> <p>The licensee failed to ensure R7's MAR instructions for albuterol matched the signed prescriber's order for quantity and how often it could be administered.</p> <p>On July 22, 2025, at 9:50 a.m., clinical nurse supervisor (CNS)-B stated she was not sure how the nurses directed measurement of topical medications when training the ULP. She further stated she would follow up with the nurses and ULP with using the proper measuring tool with the diclofenac gel as it was ordered.</p> <p>The licensee's Administration of Resident medication by licensed and unlicensed staff policy</p> | 01760                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/24/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01760                                                         | <p>Continued From page 34</p> <p>dated August 2021, indicated Medications always need to be administered according to the "6 Rights"</p> <ul style="list-style-type: none"><li>a. Right person</li><li>b. Right medication</li><li>c. Right time</li><li>d. Right route (by mouth, eye drops, to the skin, etc.)</li><li>e. Right dose (how many milligrams, drops, etc.)</li><li>f. Right chart/record to document that the medication was taken</li></ul> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days.</p>                                                                                                                                                                                                                                              | 01760                                                                  |                                                                                                                          |  |                                                     |
| 01770<br>SS=F                                                 | <p><b>144G.71 Subd. 9</b> Documentation of medication setup</p> <p>Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup included the required content 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, but was not likely to cause serious injury, impairment, or death), and</p> | 01770                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/24/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01770                                                         | <p>Continued From page 35</p> <p>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>During the entrance conference on July 21, 2025, at 11:30 a.m. clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to their residents, including medication setup. LALD-A stated the licensee used a long-term care pharmacy; however, when new residents came with their home supply, the licensee's registered nurses (RN) set up the medications in med-minders (plastic pill boxes) until that supply ended and the long-term pharmacy started filling and packaging them.</p> <p>R1's Service Plan dated April 28, 2025, indicated she received level 1 memory care services which included assistance with medication administration, bathing, dressing, grooming, transfers and ambulation, and toileting. R1's Service Plan lacked medication set up services.</p> <p>R1's Medication Plan (used as part of the Service Plan) dated April 28, 2025, lacked an indication Medication Set-up was being provided.</p> <p>On July 22, 2025, at 8:10 a.m. during various medication administration observations with unlicensed personnel (ULP)-G, the surveyor observed two med-minders and were labeled for R1. ULP-G stated she had already administered the morning medications for R1. ULP-G stated the nurse set up the medications in the med-minders, the ULP counted the pills in the designated day of the week and counted how many oral medications were listed on the</p> | 01770                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/24/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01770                                                         | <p>Continued From page 36</p> <p>medication administration record (MAR) for that medication pass. She further stated if the number matched, she administered the medications.</p> <p>R1's MAR dated July 2025, included the "order" administer medications from pillboxes, twice daily, with special instructions, "administer pills from two pill boxes. Blue/purple box is for chewable AM/PM medications. Large pill box is for AM/PM pills, Administer from both in AM/PM". The MAR also indicated two PRN (as needed) medications for pain, one scheduled medication for cholesterol, one for depression, two for dementia, one for gastric reflux, one for thyroid, one for sleep, two oral powders for constipation, five supplements, one nasal spray for allergies, and one eye drop for dry eyes.</p> <p>R1's Resident Progress Notes included the following entries by the licensee's nurses:<br/>-June 23, 2025, Resident's medication set up box completed today by RN [registered nurse] for the week;<br/>-June 30, 2025, set up resident's medication in the med boxes according to current physician orders;<br/>-July 7, 2025, resident returned today from a leave over the weekend. Resident's medication set up boxes filled with current medication orders from PCP [primary care provider];<br/>-July 14, 2025, filled resident's medication set up boxes for the week using current provider medication orders; and<br/>-July 21, 2025, medications set up in residents med box per current provider orders and locked in med cart to be administered by unlicensed staff</p> <p>On July 22, 2025, at 9:48 a.m., CNS-B stated as an overall practice, the licensee's nurses did not document each medication that had been set up</p> | 01770                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/24/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01770                                                         | Continued From page 37<br><br>when they filled the med-minders but entered a progress note indicating the medication set up had been done.<br><br>The licensee failed to provide the required documentation of medication set up to include dates of medication setup, name of medication, quantity of dose, times to be administered, and route of administration.<br><br>No further information was provided.<br><br>TIME PERIOD TO CORRECT: Seven (7) Days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 01770                                                                  |                                                                                                                          |  |                                                     |
| 01880<br>SS=F                                                 | 144G.71 Subd. 19 Storage of medications<br><br>An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure the medication refrigerator maintained an acceptable temperature to ensure the medications were stored according to manufacturer's recommendations in the facility's medication refrigerator. Additionally, the licensee failed to ensure all medications were securely locked in substantially constructed compartments and permit only authorized personnel had access. This had the potential to affect the licensee's current residents, staff, and visitors.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or | 01880                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                           |                                                                                                                          |  |                                                        |
|---------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/24/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 01880                                                         | <p>Continued From page 38</p> <p>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>During the entrance conference on July 21, 2025, at 11:30 a.m., clinical nurse supervisor (CNS)-B stated the licensee had one medication cart in each of the two secured memory care buildings. The medication carts were locked when not in use. CNS-B further stated each building had a locked small medication refrigerator for any resident medications needing refrigeration and stated there were no currently stored medications in them.</p> <p>TEMPERATURE SENSITIVE MEDICATIONS</p> <p>On July 22, 2025, at 8:10 a.m. while observing unlicensed personnel (ULP)-G during medication preparation and administration, the surveyor observed a small refrigerator located next to the medication cart. The refrigerator was locked with a paddle lock and had a blank temperature monitoring log hung on the refrigerator door. The surveyor asked ULP-G about any medications being housed in the refrigerator and was told there was one medication stored for R8. ULP-G opened the refrigerator and noted two Trulicity auto injectable pens (for diabetes) in their pharmacy packaging for R8. The surveyor and ULP-G did not observe a thermometer in the refrigerator, nor did the refrigerator have evidence of a built-in thermometer. ULP-G stated she was not aware the staff should have been monitoring the</p> | 01880                                                                     |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/24/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01880                                                         | <p>Continued From page 39</p> <p>refrigerator temperature.</p> <p>R8's Trulicity packaging included instructions to store the medication between 36-46 degrees Fahrenheit (F).</p> <p>The licensee failed to store temperature sensitive medications according to the manufacturer's recommendations.</p> <p><b>SAFE MEDICATION STORAGE</b></p> <p>On July 21, 2025, at 2:10 p.m., the surveyor observed ULP-D during medication preparation and administration. ULP-D set up one medication for R2 at the medication cart, cleared the computer screen, and went to R2's room with her medication, administered it with water and returned to the medication cart. ULP-D then locked the medication cart.</p> <p>The surveyor inquired about other medication passes to which ULP-D stated she had one more to administer. She then unlocked the medication cart and set up one medication for R4. She cleared the computer screen and walked to the living room area with the medication, again leaving the medication cart unlocked. After R4's medication administration was completed, another resident asked for assistance to the bathroom. ULP-D left the area and assisted that resident, never returning to lock the medication cart. The surveyor observed another resident wandering in the secured memory care unit near the unlocked medication cart. No other ULP were present to ensure medications were secure.</p> <p>On July 22, 2025, at 9:50 a.m., CNS-B stated the medication carts needed to be locked if unattended by staff. She further stated she was</p> | 01880                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/24/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01880                                                         | <p>Continued From page 40</p> <p>not aware the medication refrigerator temperature was not being monitored to ensure proper medication storage.</p> <p>The licensee's Secured Storage of Medications policy dated August 2024, indicated all medication for residents residing in our memory care homes will have secured storage of meds in a central storage area; to be stored in a locked medication cart. Stock medication for general use will be locked in the medication cart.</p> <p>-Resident medication needing to be refrigerated will be stored in the medication refrigerator. This refrigerator will be locked, and access will be given only to authorized personnel. Medications kept in secured storage must be kept in locked compartments under proper temperature controls and only authorized nursing personnel will have access to the keys.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p> | 01880                                                                  |                                                                                                                          |  |                                                     |
| 01890<br>SS=D                                                 | <p>144G.71 Subd. 20 Prescription drugs</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:<br/>Based on observation, interview, and record review, the licensee failed to label a time sensitive</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 01890                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/24/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01890                                                         | <p>Continued From page 41</p> <p>medication with an opened date for one of seven residents (R7) with medication administration.</p> <p>This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).</p> <p>The findings included:</p> <p>R7's Service Plan dated February 4, 2025, included the services of medication management/administration.</p> <p>R7's signed prescriber's orders dated June 4, 2025, indicated Arnuity Ellipta 100 microgram (mcg) inhalation powder, give one puff daily (rinse mouth and throat after use) for chronic lung disease.</p> <p>On July 22, 2025, at 7:58 a.m., the surveyor observed unlicensed personnel (ULP)-G to administer nine oral medications and one inhaler. R7's Arnuity inhaler was administered as directed and R7 rinsed her mouth. The surveyor observed no open date on the inhaler, nor on the box holding the inhaler. The inhaler's label indicated "discard after six weeks". The inhaler had 21 doses of medication remaining. ULP-G stated she was not aware of the need to indicate an open date with some medications.</p> <p>On July 22, 2025, at 9:55 a.m., clinical nurse supervisor (CNS)-B stated she felt the ULP forgot to write the open date on the medication once</p> | 01890                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/24/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01890                                                         | Continued From page 42<br><br>opened.<br><br>The licensee's Secured Storage of Medications policy dated August 2024, indicated until the medication is set up for immediate or later administration by a nurse, a legend drug must be kept in its original container bearing the original prescription label with legible information stating the prescription number, name of drug, strength and quantity of drug, expiration date of time-dated drug, directions for use, resident's name, prescriber's name, date of issue and the name and address of the licensed pharmacy that issued the medications.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days                                                                                                                  | 01890                                                                  |                                                                                                                          |  |                                                     |
| 01950<br>SS=E                                                 | 144G.72 Subd. 4 Administration of treatments and therapy<br><br>Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has:<br>(1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; | 01950                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/24/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01950                                                         | <p>Continued From page 43</p> <p>(2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) specified, in writing, specific instructions and documented those instructions in the resident record for two of three residents (R5, R7) with treatments.</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>R5<br/>R5 was admitted to the facility under the Assisted Living with Dementia Care license on September 18, 2024, with diagnoses including Alzheimer's disease.</p> <p>R5's Service Plan dated September 18, 2024, included the services of medication management/administration, assistance with bathing, dressing, grooming and meal preparation. R5's Service Plan lacked the service of wound care.</p> <p>R5's undated, Treatment Plan (used as part of</p> | 01950                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/24/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01950                                                         | <p>Continued From page 44</p> <p>the Service Plan) indicated "No current treatments".</p> <p>On July 22, 2025, at 7:00 a.m., unlicensed personnel (ULP)-H stated R5 had a left buttock wound dressing that was managed by an outside agency RN. ULP-H stated the ULP were only to replace the dressing as needed if soiled or coming loose. ULP-H stated the home health RN was scheduled to come today to provide wound care and a dressing change.</p> <p>On July 22, 2025, at 9:40 a.m., clinical nurse supervisor (CNS)-B stated [outside agency home health company] RN completed weekly wound care and dressing changes. She stated the licensee ULP were monitoring R5's Mepilex dressing and replacing it if soiled or loose.</p> <p>On July 22, 2025, at 11:30 a.m., the surveyor met the outside agency home health care RN in the bathroom where she had provided wound care to R5's left upper buttock wound. She stated she used a spray wound cleanser to the wound, pat dried the wound area and placed Opti cell Ag (a special wound packing) inside the wound area and covered with a clear Mepilex border dressing. The home care RN stated the licensee ULP were only to replace the Mepilex border if it was soiled or coming loose; however, the ULP/licensee were not to apply the Opti cell Ag dressing.</p> <p>R5's progress notes for the previous six months were requested. Resident progress notes dated January 29, 2025, through July 10, 2025, were provided. The only entry regarding R5's buttock wound was dated March 7, 2025, which indicated, "Resident buttocks wound is now open. Applied barrier cream and new Mepilex dressing to open sore. Discussed situation with [home health</p> | 01950                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/24/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01950                                                         | <p>Continued From page 45</p> <p>agency name] nurse who is doing home health wound care. She is planning to see the resident Monday for a recertification of services, and she plans to up his frequency of visits. A POC [plan of care] update will be provided in the care plan regarding wound dressing."</p> <p>R5's record included a wound care order dated February 17, 2025, indicated apply Mepilex pad to coccyx wound on left buttock every two to three days or change if soiled. The order included special instructions, "Change every two to three days or if soiled with stool. Remove and apply new bandage after showers. Apply barrier cream (past) prior to placing new Mepilex dressing. If no Mepilex available, apply barrier cast to wound and clean brief. Wound care to see resident this week to get more supplies."</p> <p>R5's document (known as the care plan) included a section with wound care updated on March 7, 2025, included the "Problem" pressure ulcer/injury-Stage one pressure ulcer noted on coccyx, with "Approach" indicating the instruction for ULP to cleanse skin during shower with warm soap and water. Pat dry with clean towel. Apply Mepilex border to tailbone. Change on shower days or if soiled. Report signs of infection to nurse (increased size, redness, color, colored drainage).</p> <p>R5's medication administration record (MAR) dated July 2025, indicated cleanse skin during shower with warm soap and water. Pat dry with clean towel. Apply Mepilex border to tailbone. Change on shower days or if soiled. Report signs of infection to nurse (increased sized, redness, odor, colored drainage). The task was assigned once daily on Mondays and Thursdays. The MAR included staff initials indicating completion on July</p> | 01950                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/24/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01950                                                         | <p>Continued From page 46</p> <p>3, 7, 10, 14, 17, 21, 2025.</p> <p>On July 24, 2025, at 1:00 p.m., CNS-B stated she was uncertain exactly what the ULP were doing with R5's wound, as the documentation was confusing. She stated she thought they were documenting that they were ensuring R5's dressing was in place and intact. CNS-B stated there had been several changes over the course of the last several months in who was managing the wound and how it was being managed. CNS-B stated she would need to look further into what the ULP were doing and indicated the written instructions by the nurse were unclear.</p> <p>The licensee failed to ensure R5's record included the most up to date plan of care/wound care instructions for the treatment of R5's wound.</p> <p>R7<br/>R7 was admitted to the facility under the Assisted Living with Dementia license on February 1, 2023, with a diagnoses of late onset Alzheimer's dementia, hypertension and history of pulmonary embolism (blood clot in the lung).</p> <p>R7's Service Plan dated February 4, 2025, included the treatment of compression stockings.</p> <p>On July 22, 2025, at 7:58 a.m., the surveyor observed ULP-G set up and administer R7's medications at the dining room table. ULP-G stated the ULP had already placed R7's compression stockings with morning cares and dressing. The surveyor observed R7 with compression stockings on.</p> <p>R7's Individualized Treatment and Therapy Management Plan dated February 13, 2025, indicated the treatment of compression socks,</p> | 01950                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/24/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01950                                                         | <p>Continued From page 47</p> <p>daily (put on in AM and take off in PM), with comments, "hand wash PM shift and hang to dry".</p> <p>R7's signed prescriber's orders dated June 4, 2025, (provider's visit note) indicated compression stockings on in the morning, off at night. Remove compression or loosen compression if it feels too tight or painful or is causing numbness or toes become discolored. Continue good leg care, moisturize skin on the legs. Recommend elevation of the legs above the level of the heart for 60 minutes twice daily while awake.</p> <p>R7's MAR and task documentation record dated July 2025, lacked documentation of R7's compression stockings and any other specific direction/instructions for ULP to note.</p> <p>The licensee failed to ensure R7's record included instructions for what ULP should monitor with the use of R7's compression stockings (redness, open skin, discoloration of toes, pain).</p> <p>On July 23, 2025, at 3:05 p.m. CNS-B stated she was not aware she needed to add specific instructions for the ULP to note with the use of compression stockings.</p> <p>The licensee's Delegation of Nursing Tasks, Treatments, Therapy Tasks policy dated July 2021, indicated when needed, the RN will provide written instructions for performing the procedure to the ULP. Changes in care will be communicated to the ULP and further education and instruction provided as needed.</p> <p>No further information was provided.</p> | 01950                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                         |                                                                                                                          |  |                                                        |
|---------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>20147</b>               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/24/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 01950                                                         | Continued From page 48                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 01950                                                                                   |                                                                                                                          |  |                                                        |
|                                                               | TIME PERIOD FOR CORRECTION: Seven (7)<br>days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                         |                                                                                                                          |  |                                                        |
| 01960<br>SS=D                                                 | <b>144G.72 Subd. 5 Documentation of<br/>administration of treatments</b><br><br>Each treatment or therapy administered by an<br>assisted living facility must be in the resident<br>record. The documentation must include the<br>signature and title of the person who<br>administered the treatment or therapy and must<br>include the date and time of administration. When<br>treatment or therapies are not administered as<br>ordered or prescribed, the provider must<br>document the reason why it was not administered<br>and any follow-up procedures that were provided<br>to meet the resident's needs.<br><br>This MN Requirement is not met as evidenced<br>by:<br>Based on observation, interview, and record<br>review, the licensee failed to ensure treatment<br>services were documented for one of two<br>residents (R7) with treatments.<br><br>This practice resulted in a level two violation (a<br>violation that did not harm a resident's health or<br>safety but had the potential to have harmed a<br>resident's health or safety, but was not likely to<br>cause serious injury, impairment, or death), and<br>was issued at an isolated scope (when one or a<br>limited number of residents are affected or one or<br>a limited number of staff are involved or the<br>situation has occurred only occasionally).<br><br>The findings include:<br><br>R7 was admitted to the facility under the Assisted<br>Living with Dementia license on February 1, | 01960                                                                                   |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/24/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01960                                                         | <p>Continued From page 49</p> <p>2023, with a diagnoses of late onset Alzheimer's dementia, hypertension and history of pulmonary embolism (blood clot in the lung).</p> <p>R7's Service Plan dated February 4, 2025, included the treatment of compression stockings.</p> <p>On July 22, 2025, at 7:58 a.m., the surveyor observed ULP-G set up and administer R7's medications at the dining room table. ULP-G stated the ULP had already placed R7's compression stockings with morning cares and dressing. The surveyor observed R7 with compression stockings on.</p> <p>R7's Individualized Treatment and Therapy Management Plan dated February 13, 2025, indicated the treatment of compression socks, daily (put on in AM and take off in PM), with comments, "hand wash PM shift and hang to dry".</p> <p>R7's signed prescriber's orders dated June 4, 2025, (provider's visit note) indicated compression stockings on in the morning, off at night. Remove compression or loosen compression if it feels too tight or painful or is causing numbness or toes become discolored. Continue good leg care, moisturize skin on the legs. Recommend elevation of the legs above the level of the heart for 60 minutes twice daily while awake.</p> <p>R7's medication administration record (MAR) and task documentation record dated July 2025, lacked documentation of R7's compression stockings and any other specific direction/instructions for ULP to note.</p> <p>The licensee failed to document R7's treatment of</p> | 01960                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/24/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01960                                                         | <p>Continued From page 50</p> <p>compression stockings as required.</p> <p>On July 23, 2025, at 3:05 p.m., CNS-B stated she could not see any documentation of the ULP completing the treatment of R7's compression stockings. She further stated with a switch to a new electronic medical record system (EMR) started earlier this year, there had been several "missing care plan" tasks not being captured properly.</p> <p>The licensee's Treatment and Therapies policy dated August 2021, indicated the determination of scope of treatment and therapy services the facility will offer includes documenting treatment and therapy interventions.</p> <p>No further information was provided.</p> <p>TIME PERIOD TO CORRECT: Seven (7) days.</p> | 01960                                                                  |                                                                                                                          |  |                                                     |
| 01970<br>SS=D                                                 | <p>144G.72 Subd. 6 Treatment and therapy orders</p> <p>There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months.</p> <p>This MN Requirement is not met as evidenced by:<br/>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 (R5) receiving</p>            | 01970                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/24/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01970                                                         | <p>Continued From page 51</p> <p>treatments.</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>On July 21, 2025, at 11:30 a.m. during entrance conference, clinical nurse supervisor (CNS)-B stated the licensee only managed simple wounds to the level of first aid response and outsourced more complex wound care to a local home health provider.</p> <p>R5 was admitted to the facility under the Assisted Living with Dementia Care license on September 18, 2024, with diagnoses including Alzheimer's disease.</p> <p>R5's Service Plan dated September 18, 2024, included the services of medication management/administration, assistance with bathing, dressing, grooming and meal preparation. R5's Service Plan lacked the service of wound care.</p> <p>On July 22, 2025, at 7:00 a.m., unlicensed personnel (ULP)-H stated R5 had a left buttock wound dressing that was managed by an outside agency RN. ULP-H stated the ULP were only to replace the dressing as needed if soiled or coming loose. ULP-H stated the home health RN was scheduled to come today to provide wound</p> | 01970                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/24/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01970                                                         | <p>Continued From page 52</p> <p>care and a dressing change.</p> <p>On July 22, 2025, at 9:40 a.m., CNS-B stated [outside agency home health company name] RN completed weekly wound care and dressing changes.</p> <p>On July 22, 2025, at 11:30 a.m., the surveyor met the outside agency home health care RN in the bathroom where she had provided wound care to R5's left upper buttock wound. She stated she used a spray wound cleanser to the wound, pat dried the wound area and placed Opti cell Ag (a special wound packing) inside the wound area and covered with a clear Mepilex border dressing. The home care RN stated the licensee ULP were only to replace the Mepilex border if it was soiled or coming loose; however, the ULP/licensee were not to apply the Opti cell Ag dressing.</p> <p>R5's record included a wound care order dated February 17, 2025, indicated apply Mepilex pad to coccyx wound on left buttock every two to three days or change if soiled. The order included special instructions, "Change every two to three days or if soiled with stool. Remove and apply new bandage after showers. Apply barrier cream (paste) prior to placing new Mepilex dressing. If no Mepilex available, apply barrier paste to wound and clean brief. Wound care to see resident this week to get more supplies."</p> <p>R5's resident progress note dated March 7, 2025, indicated, "Resident buttocks wound is now open. Applied barrier cream and new Mepilex dressing to open sore. Discussed situation with [home health agency name] nurse who is doing home health wound care. She is planning to see the resident Monday for a recertification of services, and she plans to up his frequency of visits. A</p> | 01970                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/24/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01970                                                         | <p>Continued From page 53</p> <p>POC [plan of care] update will be provided in the care plan regarding wound dressing."</p> <p>R5's document (known as the care plan) included a section with wound care updated on March 7, 2025, included the "Problem" pressure ulcer/injury-Stage one pressure ulcer noted on coccyx, with "Approach" indicating the instruction for ULP to cleanse skin during shower with warm soap and water. Pat dry with clean towel. Apply Mepilex border to tailbone. Change on shower days or if soiled. Report signs of infection to nurse (increased size, redness, color, colored drainage).</p> <p>R5's medication administration record (MAR) dated July 2025, indicated cleanse skin during shower with warm soap and water. Pat dry with clean towel. Apply Mepilex border to tailbone. Change on shower days or if soiled. Report signs of infection to nurse (increased sized, redness, odor, colored drainage). The task was assigned once daily on Mondays and Thursdays. The MAR included staff initials indicating completion on July 3, 7, 10, 14, 17, 21, 2025.</p> <p>On July 24, 2025, at 1:00 p.m., CNS-B stated the home health agency had not shared any updated wound care orders with the licensee and she was unable to find an updated order for the current as needed (PRN) management of R5's wound. CNS-B further stated she would need to verify with ULP as to what they were doing with R5's wound and when they were replacing the Mepilex dressing. She stated documentation on the MAR indicated they may have been completing dressing changes on shower days (twice weekly).</p> <p>The licensee failed to ensure an updated wound care order was maintained for R5's current</p> | 01970                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/24/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01970                                                         | Continued From page 54<br><br>wound care routine.<br><br>The licensee's Implementation of Medication Prescriptions and Treatment and Therapy Orders policy dated August 2021, indicated a current, written prescriber's order must be obtained for any treatment to be provided to a resident.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 01970                                                                  |                                                                                                                          |  |                                                     |
| 02040<br>SS=E                                                 | 144G.81 Subdivision 1 Fire protection and physical environment<br><br>An assisted living facility with dementia care must meet the requirements of section 144G.45 and the following additional requirements:<br>(1) an assessment of safety risks must be performed on and around the property. The safety risks identified by the facility on the assessment must be mitigated to protect the residents from harm. The mitigation efforts must be documented in the facility's records; and<br>(2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029.<br><br>This MN Requirement is not met as evidenced by:<br>Based on record review and interview, the licensee failed to provide a safety risk assessment or hazard vulnerability assessment of the physical environment on and around the property with mitigation factors.<br>This practice resulted in a level two violation (a | 02040                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/24/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 02040                                                         | Continued From page 55<br><br>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).<br>Findings include:<br>On July 23, 2025, a safety risk assessment or hazard vulnerability assessment for the physical environment was requested by the surveyor. A hazard vulnerability assessment was provided by licensed assisted living director /registered nurse (LALD/RN)-A. The assessment had been completed for emergency preparedness and was not specific to the physical environment. Additionally, the assessment did not include mitigation of identified hazards to protect dementia care residents from harm. During an interview on July 23, 2025, at 12:50 p.m., LALD/RN-A verified a safety risk assessment or hazard vulnerability assessment with mitigation factors for the physical environment on and around the property was not available, and if located, would be emailed to the surveyor today no later than 4:00 p.m. No further information was received.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 02040                                                                  |                                                                                                                          |  |                                                     |
| 02170<br>SS=E                                                 | 144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA<br><br>(b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 02170                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/24/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 02170                                                         | <p>Continued From page 56</p> <p>(1) past and current interests;<br/>(2) current abilities and skills;<br/>(3) emotional and social needs and patterns;<br/>(4) physical abilities and limitations;<br/>(5) adaptations necessary for the resident to participate; and<br/>(6) identification of activities for behavioral interventions.</p> <p>(c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs.</p> <p>(d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to:</p> <p>(1) occupation or chore related tasks;<br/>(2) scheduled and planned events such as entertainment or outings;<br/>(3) spontaneous activities for enjoyment or those that may help defuse a behavior;<br/>(4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music;<br/>(5) spiritual, creative, and intellectual activities;<br/>(6) sensory stimulation activities;<br/>(7) physical activities that enhance or maintain a resident's ability to ambulate or move; and<br/>(8) outdoor activities.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on interview and record review, the licensee failed to conduct an evaluation for activities that addressed all provisions and failed to develop an individualized activity plan with all the required content based on the evaluation, for two of two residents (R5, R7) who received</p> | 02170                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/24/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 02170                                                         | <p>Continued From page 57</p> <p>services under an assisted living with dementia care license.</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>R5<br/>R5 was admitted to the facility's secured memory care unit on September 18, 2024, with diagnoses including Alzheimer's disease.</p> <p>R5's Service Plan dated September 18, 2024, included the services of medication management/administration, assistance with bathing, dressing, grooming, meals and housekeeping.</p> <p>R7<br/>R7 was admitted to the facility's secured memory care unit on February 1, 2023, with diagnoses including late onset Alzheimer's dementia, hypertension and history of pulmonary embolism (blood clot in the lungs).</p> <p>R7's Service Plan dated February 4, 2025, included the services of medication management/administration, compression stockings, and assistance with bathing, dressing, grooming, and housekeeping.</p> | 02170                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>20147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>07/24/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b>                                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 02170                                                         | <p>Continued From page 58</p> <p>R5 and R7's records lacked evidence they had been evaluated for activities to include the following required content:</p> <ul style="list-style-type: none"><li>(1) past and current interests;</li><li>(2) current abilities and skills;</li><li>(3) emotional and social needs and patterns;</li><li>(4) physical abilities and limitations;</li><li>(5) adaptations necessary for the resident to participate; and</li><li>(6) identification of activities for behavioral interventions.</li></ul> <p>(c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs.</p> <p>(d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to:</p> <ul style="list-style-type: none"><li>(1) occupation or chore related tasks;</li><li>(2) scheduled and planned events such as entertainment or outings;</li><li>(3) spontaneous activities for enjoyment or those that may help defuse a behavior;</li><li>(4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music;</li><li>(5) spiritual, creative, and intellectual activities;</li><li>(6) sensory stimulation activities;</li><li>(7) physical activities that enhance or maintain a resident's ability to ambulate or move; and</li><li>(8) outdoor activities.</li></ul> <p>On July 23, 2025, at 10:07 a.m., clinical nurse supervisor (CNS)-B stated she was unable to find either resident's activity assessment or activity plan; she further stated the licensee had been completing an activity assessment and plan for</p> | 02170                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                               |                                                                                                                                                                                                                                                |                                                                                         |                                                                                                                          |  |                                                        |
|---------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION           |                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>20147</b>               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/24/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADITH MILLER MANOR</b> |                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>885 MANKATO AVENUE<br/>WINONA, MN 55987</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                   | ID<br>PREFIX<br>TAG                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 02170                                                         | <p>Continued From page 59</p> <p>each resident at time of admission but was<br/>unsure if/when these were completed for R5 and<br/>R7.</p> <p>No further information provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one<br/>(21) days</p> | 02170                                                                                   |                                                                                                                          |  |                                                        |





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

## Food & Beverage Inspection Report

Page: 1

### Establishment Info

Adith Miller Manor  
885 Mankato Ave  
Winona, MN 55987  
Winona County  
Parcel:  
  
Phone:

### License Info

License: HFID20147  
  
Risk:  
License:  
Expires on:  
CFPM: Tanya Johnson  
CFPM #: FM62549; Exp: 6/6/2027

### Inspection Info

Report Number: F1009251046  
Inspection Type: Full - Single  
Date: 7/22/2025 Time: 10:11:58 AM  
Duration: 90 minutes  
Announced Inspection: No  
**Total Priority 1 Orders: 2**  
Total Priority 2 Orders: 0  
Total Priority 3 Orders: 0  
Delivery: Emailed

### ! New Order: 3-500B Microbial Control: hot and cold holding

3-501.16A2      *Priority Level: Priority 1*    CFP#: 22

*MN Rule 4626.0395A2* Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

**COMMENT: Foods in the refrigerator in Roger Metz Manor measured 44°F. Lower the temperature and monitor food temperatures closely.**

**The unit was adjusted, and a service call was made during the inspection. There are very few TCS items in the refrigerator.**

*Comply By: 7/22/2025      Originally Issued On: 7/22/2025*

### ! New Order: 7-200 Toxic Supplies and Applications

7-204.11      *Priority Level: Priority 1*    CFP#: 28

*MN Rule 4626.1620* Discontinue using chemical sanitizers, including chemical sanitizing solutions generated on site and other chemical antimicrobials on food-contact surfaces that do not meet the requirements specified in 40 CFR part 180, section 180.940, or part 180, subpart E, section 180.2020.

**COMMENT: The Quat sanitizer spray bottle labeled for kitchen food contact surfaces in Roger Metz Manor kitchen contains a purple colored liquid that was identified as Betco Quat-Stat 5 disinfectant virucide cleaner. This cleaner is not a safe food contact surface sanitizer. Replace this with the Quat solution that is listed for food contact surface sanitizing.**

*Comply By: Complied On Site      Originally Issued On: 7/22/2025*

## Food & Beverage General Comment

Breakfast, lunch, and dinner are prepared in the hospital kitchen at Winona Health, and transported to the two buildings in Cambros immediately before service time. The food temperatures are taken and recorded prior to leaving the hospital, and again when served.

Pasteurized eggs are used.

Meal leftovers are not saved. They are sent back to the hospital where they are discarded. The log book of temperatures was reviewed.

Cooler air temperatures are monitored but not documented. I recommend measuring the temperature of an actual food product in the cooler rather than the coolers digital set temperature or relying on the ambient air thermometer inside the cooler, which often becomes inaccurate. This will give you more accurate information about the food. I also recommend documenting these temperatures in the same way the hot food temperatures are documented.



I also recommend documenting sanitizer concentrations/temperatures.

Observed good date-marking practices.

Employee illness symptoms are reported and recorded.

Establishment contracts with Plunkett's for pest management. No pest issues observed.

Facilities are found to be clean and well-maintained today.

---

Please be aware that Norovirus, often thought to be the "stomach flu" continues to be the leading cause of foodborne illness outbreaks. A person who has contracted Norovirus continues to be contagious at least three days after symptoms have subsided. Because of this, it is important to report and record any illnesses, even if staff did not report to work while ill.

Also, to further reduce the risk of transmitting Norovirus and other pathogens, continue to closely monitor handwashing, proper cleaning and sanitizing of equipment and surfaces, and do not allow bare-hand contact with ready-to-eat foods.

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

**I acknowledge receipt of the Rochester District Office inspection report number F1009251046 from 7/22/2025**



---

Tanya Johnson  
Director of Environmental and Risk Management Services

---

Lesli Haines,  
Public Health Sanitarian 3  
507-206-2745  
lesli.haines@state.mn.us