



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

June 1, 2026

Licensee

Colleens Caring Hands Inc.
2525 Bemidji Avenue North
Bemidji, MN 56601

RE: Project Number(s) SL30648016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 22, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;

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

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

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

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

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

pursuant to this survey:

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

0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - \$1,000.00

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

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

To submit a hearing request, please visit:

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

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

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

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in cursive script that reads "Kelly Thorson". The signature is written in dark ink on a white background.

Kelly Thorson, Supervisor

State Evaluation Team

Email: kelly.thorson@state.mn.us

Telephone: 320-223-7336 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/22/2026
NAME OF PROVIDER OR SUPPLIER COLLEENS CARING HANDS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2525 BEMIDJI AVENUE NORTH BEMIDJI, MN 56601		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30648016-0 On April 20, 2026, through April 22, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were nine residents; nine receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum 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

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

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated April 21, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480			

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0 480	Continued From page 3	0 480			
	TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.				
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services (a) All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not require any resident to include and pay for meals as a part of their assisted living contract. In addition, the licensee failed to provide a weekly menu at least one week in advance. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when	0 485			

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0 485	Continued From page 4 problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on April 20, 2026, at 10:46 a.m., assisted living director in residency/clinical nurse supervisor (ALDIR/CNS)-B stated the licensee were familiar with current minimum assisted living requirements. On page three of [licensee] Resident Contract, dated May 3, 2021, section labeled 'Included Services' indicated a resident's monthly base fee included three meals daily with snacks. Resident assisted living contracts lacked an option for residents to opt out of payment for one, two, or three meals residents would not want. On April 20, 2026, at 1:46 p.m., ALDIR/CNS-B stated the same version of contract was used for all current residents. On April 20, 2026, at 1:09 p.m., owner/unlicensed personnel (O/ULP)-A stated O/ULP-A created menus for the facility one week at a time and posted the menu on the day it began. O/ULP-A further stated the current week's menu had been started but not completed upon the surveyor's arrival, today. On April 22, 2026, at 11:46 a.m., ALDIR/CNS-B stated the cost of meals was included as part of a resident's monthly rent. ALDIR/CNS-B further stated ALDIR/CNS-B was not aware of the requirement which provided resident's an opportunity to opt out of one, two, or three meals and indicated the contract will need to be	0 485			

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0 485	Continued From page 5 updated. The Minnesota Department of Health Assisted Living Resources and Frequently Asked Questions (FAQs) website, last updated October 13, 2025, indicated the provider cannot have a blanket "one size fits all" meal charge. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485			
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement and maintain a quality management program appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all current residents, staff, and visitors.	0 580			

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0 580	Continued From page 6 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on April 20, 2026, at 12:26 p.m., assisted living director in residency/clinical nurse supervisor (ALDIR/CNS)-B stated the licensee had not held quality assurance (QA) meetings as often as desired. ALDIR/CNS-B further stated the licensee had not held a QA meeting in approximately one year. On April 22, 2026, at 12:09 p.m., ALDIR/CNS-B stated ALDIR/CNS-B was unsure where prior QA meeting minutes documentation was located at the time, thus, ALDIR/CNS-B could not provide quality management documentation for review. The licensee's 2.31 Quality Management Project policy dated February 20, 2026, indicated [licensee] always documented at least one current quality management project and retained quality management records for at least two years. The policy further indicated quality management documentation was to be made available, upon request, to MDH (Minnesota Department of Health) surveyors. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 580			

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0 580	Continued From page 7 (21) days	0 580			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and post a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors of the facility.	0 680			

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0 680	Continued From page 8 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on April 20, 2026, at 10:46 a.m., assisted living director in residency/clinical nurse supervisor (ALDIR/CNS)-B stated the licensee was familiar with current minimum assisted living requirements. The licensee's undated EPP lacked the following content and/or policies and procedures to address: - evidence of annual review of the EPP; - identify at risk population needs like maintaining independence, communication, transportation, supervision and medical care; - process for cooperation and collaboration with local, tribal, regional, state and federal EP to maintain an integrated response; - the provision of subsistence needs for staff and residents to include (food, water, medical supplies, pharmacy supplies, sewer and waste disposal, emergency lighting); - system to track the location of on-duty staff and sheltered residents; - evacuation plan to include staff responsibilities during an evacuation; - how the facility will provide a means to shelter in place for residents;	0 680			

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0 680	Continued From page 9 - the medical record documentation system the facility has developed to preserve resident information security and availability of records; - policy and procedure to address the use of volunteers; - policy and procedure addressing development of arrangements with other facilities/providers to received residents in the event of limitations/cessation of operations to maintain the continuity of services to residents; - the facilities role in providing care and treatment at alternative sites under a 1135 waiver; - a communication plan to include: - names and contact information for staff, residents' physicians, other facilities; - contact information state licensing agency and Minnesota Office of Ombudsman for LTC (long-term care); - primary and alternate means of communicating with facility staff and emergency management agencies; - a method for sharing information and medical documentation for residents; - means to providing information about the facility's occupancy, needs, and its ability to provide assistance; - a method for sharing information from the emergency plan with residents and their families; - develop and maintain EP training and testing program; and - conduct exercises to test the EPP at least twice per year, including unannounced staff drills using the EPP. On April 21, 2026, at 11:40 a.m., ALDIR/CNS-B state ALDIR/CNS-B was given an incomplete EPP when ALDIR/CNS-B was hired and although ALDIR/CNS-B has worked on parts of the EPP, there continued to be missing portions.	0 680			

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0 680	Continued From page 10 The licensee's 9.01 Emergency Preparedness Plan- Appendix Z Compliance policy dated December 15, 2023, indicated the [licensee]'s EPP included all required elements of appendix Z, was reviewed annually, and was based on the facility and community-based risk assessments. In addition, the policy indicated [licensee]'s EPP included policies and procedures designed to align with the LTC (long term care) requirements in Appendix Z and a communications plan which focused on staff, entities under arrangement, other LTC providers, volunteers, family members, state and federal contacts, and other sources of assistance. The policy further indicated training was provided to staff upon hire and annually and at minimum, two emergency preparedness drills- one full-scale community-wide exercise and a second either full-scale or tabletop drills- were completed every 12 months to test the EPP and identify gaps or areas for improvement. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0100, sections A and B, effective October 2022, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 775	Continued From page 11	0 775			
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated April 20, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Sevey (7) days.	0 775			
0 790 SS=C	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment	0 790			

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0 790	Continued From page 12 (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated April 20, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Two (2) days.	0 790			

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0 800	Continued From page 13	0 800			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated April 20, 2026, for the specific violations related the physical environment under Minnesota Statute 144G.	0 800			

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0 800	Continued From page 14	0 800			
	TIME PERIOD FOR CORRECTION: Twenty One (21) days.				
0 810 SS=I	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	0 810			

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0 810	Continued From page 15 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated April 20, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	0 810			
0 940 SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical	0 940			

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0 940	Continued From page 16 assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the assisted living contract included all required content for one of one resident (R8). This had the potential to affect all residents who received assisted living services. This practice resulted in a level one violation (a	0 940			

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0 940	Continued From page 17 violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Following the entrance conference on April 20, 2026, at 12:58 p.m., the surveyor requested via email a copy of the assisted living contract, which was later provided for review. R3 admitted to the licensee on November 22, 2025. R3's [licensee] Assisted Living Contract was signed on December 7, 2025, to receive assisted living services. R3's service plan dated November 25, 2025, indicated services included assistance with activities of daily living (ADLs), toileting, bathing, medication administration, assistance with tube feeding and flushes, laundry, housekeeping, and safety checks. On April 21, 2026, at 7:57 a.m., the surveyor observed unlicensed personnel (ULP)-E administer R3's scheduled morning medications and treatments. R3's [licensee] Assisted Living Contract lacked a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I including: - whether the facility is enrolled with the commissioner of human services to provide	0 940			

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0 940	Continued From page 18 customized living services under medical assistance waivers; - whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); - whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; - whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; - a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; - a statement that residents may be eligible for assistance with rent through the housing support program; - a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; - the contact information to obtain long-term care consulting services under section 256B.0911; and - the toll-free phone number for the Minnesota Adult Abuse Reporting Center. On April 20, 2026, at 1:46 p.m., assisted living director in residency/clinical nurse supervisor (ALDIR/CNS)-B stated all current residents received and signed the same contract as was provided for review. On April 22, 2026, at 11:40 a.m., ALDIR/CNS-B stated ALDIR/CNS-B was aware that the contract was required to include the information listed above and ALDIR/CNS-B was unsure why it was	0 940			

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0 940	Continued From page 19 not included in the contract. ALDIR/CNS-B further stated the contract template was received from a third-party and ALDIR/CNS-B and owner (O)/ULP-A needed to review the assisted living statutes for required contract content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 940			
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure background studies were affiliated with the correct health facility identification (HFID) 30648 for two of 16 employees (unlicensed personnel (ULP)-C and ULP-D).	01290			

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01290	Continued From page 20 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on April 20, 2026, at 12:04 p.m., assisted living director in residency/clinical nurse supervisor (ALDIR/CNS)-B stated, the licensee was aware of the required contents of the employee record. On April 20, 2026, at 2:26 p.m., ALDIR/CNS-B provided the licensee's NETStudy 2.0 (background study website) roster screenshots for HFID 30648. ULP-C ULP-C was hired on June 1, 2024, to provide direct care services to residents. ULP-C's employee record contained a cleared background study for HFID 95450, dated May 1, 2023. ULP-D ULP-D was hired on February 21, 2025, to provide direct care services to residents. On April 21, 2026, at 7:26 a.m., the surveyor observed ULP-D assist R9 with ambulation and toileting. ULP-D's employee record contained a cleared	01290			

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01290	Continued From page 21 background study for HFID 95450, which was assigned to the licensee's previous homecare license, dated January 19, 2025. ULP-C and ULP-D's employee records lacked a cleared background study affiliated with the licensee's HFID 30648. On April 20, 2026, at 3:02 p.m., ALDIR/CNS-B stated ALDIR/CNS-B or owner (O)/ULP-A initiated a background study for every employee upon hire and if a cleared background study was not completed, the licensee would not be notified if the employee became ineligible to work. On April 20, 2026, at 3:42 p.m., ALDIR/CNS-B stated there was confusion with the licensee's DHS (Department of Human Services) NETStudy accounts when the licensee established a new HFID for the assisted living license. ALDIR/CNS-B further stated the above-mentioned employees had background studies affiliated to an HFID account that was not monitored or used and needed to be affiliated to HFID 30648. The licensee's 4.02 Background Studies policy dated March 9, 2026, indicated [licensee] conducted a Minnesota DHS background study on all employees, volunteers, and contractors at [licensee]. The policy further indicated no employee was allowed to provide direct services and have independent direct contact with any residents until acceptable results were received. The policy did not address affiliation to the licensee's HFID number. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2)	01290			

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01290	Continued From page 22 days	01290			
01370 SS=E	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family;	01370			

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01370	Continued From page 23 (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency was completed for two of three employees (unlicensed personnel (ULP)-C and ULP-D) to include all required content. 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). The findings include: During the entrance conference on April 20, 2026, at 12:04 p.m., assisted living director in residency/clinical nurse supervisor (ALDIR/CNS)-B stated the licensee was aware of required contents in an employee record. ALDIR/CNS-B further stated newly hired employees completed knowledge training through EduCare (online training software), skills training with ALDIR/CNS-B, and demonstrated competency to ALDIR/CNS-B before working with residents independently. ULP-C ULP-C was hired June 1, 2024, to provide direct	01370			

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01370	Continued From page 24 care services to residents. ULP-C's employee record lacked evidence of training for the following topics: - maintenance of a clean and safe environment; - medication, exercise, and treatment reminders; ULP-D ULP-D was hired February 21, 2025, to provide direct care services to residents. On April 21, 2026, at 7:26 a.m., the surveyor observed ULP-D assist R9 with ambulation and toileting. ULP-D's employee record lacked evidence of training for the following topics: - documentation requirements for all services provided; - reports of changes in the resident's condition to the supervisor designated by the facility; - maintenance of a clean and safe environment; - care and use of hearing aids; - training on the prevention of falls for providers working with the elderly or individuals at risk of falls; - standby assistance techniques and how to perform them; - preparation of modified diets as ordered by a licensed health professional; - understanding appropriate boundaries between staff and residents and the resident's family; and - awareness of commonly used health technology equipment and assistive devices. On April 21, 2026, at 7:37 a.m., ULP-D stated ULP-D had completed computer education issued through EduCare prior to skills training and competency sign-off with ALDIR/CNS-B. ULP-D further stated all training and	01370			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01370	Continued From page 25 competencies were required to be completed before ULP-D was allowed to work independently with residents. On April 22, 2026, at 12:05 p.m., ALDIR/CNS-B stated ALDIR/CNS-B issued orientation training courses through EduCare which were completed by all employees prior to skills training and competency sign-off with ALDIR/CNS-B. ALDIR/CNS-B further stated ALDIR/CNS-B was aware of the required courses for orientation and ALDIR/CNS-B was unsure why the missing training was not completed. The licensee's undated 4.18 Employee General Orientation policy indicated upon hire and prior to performing any functions of the employee's position at [licensee], each new employee was oriented in accordance with state and federal regulations. The policy further indicated an employee was not to perform job duties before general and safety orientation was completed. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0190, Subp. 6, effective October 2022, the licensee must maintain a record of staff training and competency required under this part and Minnesota Statutes, chapter 144G, that documents the following information for each competency evaluation, training, retraining, and orientation topic: (1) facility name, location, and license number; (2) name of the training topic or training program, and the training methodology, such as classroom style, web-based training, video, or one-to-one training; (3) date of the training and competency evaluation, and the total amount of time of the training and competency evaluation; (4) name and title of the instructor and the	01370			

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01370	Continued From page 26 instructor's signature, and the name and title of the competency evaluator, if different from the instructor, and the evaluator's signature with a statement attesting that the employee successfully completed the training and competency evaluation; and (5) name and title of the staff person completing the training, and the staff person's signature with statement attesting that the staff person successfully completed the training as described in the training documentation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370			
01380 SS=E	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced	01380			

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01380	Continued From page 27 by: Based on observation, interview, and record review, the licensee failed to ensure training and competency was completed for two of three employees (unlicensed personnel (ULP)-C and ULP-D) to include all required content. 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). The findings include: During the entrance conference on April 20, 2026, at 12:04 p.m., assisted living director in residency/clinical nurse supervisor (ALDIR/CNS)-B stated the licensee was aware of required contents in an employee record. ALDIR/CNS-B further stated newly hired employees completed knowledge training through EduCare (online training software), skills training with ALDIR/CNS-B, and demonstrated competency to ALDIR/CNS-B before working with residents independently. ULP-C ULP-C was hired June 1, 2024, to provide direct care services to residents. ULP-C's employee record lacked evidence of training for the following topic: - administering medications or treatments as required.	01380			

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01380	Continued From page 28 ULP-D ULP-D was hired February 21, 2025, to provide direct care services to residents. On April 21, 2026, at 7:26 a.m., the surveyor observed ULP-D assist R9 with ambulation and toileting. ULP-D's employee record lacked evidence of training for the following topic: - observation, reporting, and documenting of resident status. On April 21, 2026, at 7:37 a.m., ULP-D stated ULP-D had completed computer education issued through EduCare prior to skills training and competency sign-off with ALDIR/CNS-B. ULP-D further stated all training and competencies were required to be completed before ULP-D was allowed to work independently with residents. On April 22, 2026, at 12:05 p.m., ALDIR/CNS-B stated ALDIR/CNS-B issued orientation training courses through EduCare which were completed by all employees prior to skills training and competency sign-off with ALDIR/CNS-B. ALDIR/CNS-B further stated ALDIR/CNS-B was aware of the required courses for orientation and ALDIR/CNS-B was unsure why the missing training was not completed. The licensee's undated 4.18 Employee General Orientation policy indicated upon hire and prior to performing any functions of the employee's position at [licensee], each new employee was oriented in accordance with state and federal regulations. The policy further indicated an	01380			

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01380	Continued From page 29 employee was not to perform job duties before general and safety orientation was completed. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0190, Subp. 6, effective October 2022, the licensee must maintain a record of staff training and competency required under this part and Minnesota Statutes, chapter 144G, that documents the following information for each competency evaluation, training, retraining, and orientation topic: (1) facility name, location, and license number; (2) name of the training topic or training program, and the training methodology, such as classroom style, web-based training, video, or one-to-one training; (3) date of the training and competency evaluation, and the total amount of time of the training and competency evaluation; (4) name and title of the instructor and the instructor's signature, and the name and title of the competency evaluator, if different from the instructor, and the evaluator's signature with a statement attesting that the employee successfully completed the training and competency evaluation; and (5) name and title of the staff person completing the training, and the staff person's signature with statement attesting that the staff person successfully completed the training as described in the training documentation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380			
01470 SS=E	144G.63 Subd. 2 Content of required orientation	01470			

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01470	Continued From page 30 (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must	01470			

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01470	Continued From page 31 include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure orientation to assisted living statutes included all the required content for two of three employees (unlicensed personnel (ULP)-D and registered nurse (RN)-G). 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). The findings include:	01470			

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01470	Continued From page 32 During the entrance conference on April 20, 2026, at 12:04 p.m., assisted living director in residency/clinical nurse supervisor (ALDIR/CNS)-B stated the licensee was aware of required contents in an employee record. ULP-D ULP-D was hired February 21, 2025, to provide direct care services to residents. On April 21, 2026, at 7:26 a.m., the surveyor observed ULP-D assist R9 with ambulation and toileting. ULP-D's employee record contained an EduCare (online training software) transcript of ULP-D's completed courses however, ULP-D's employee record lacked the following required orientation topics: - an overview of chapter 144G; - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; - compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; - consumer advocacy services of the Office of Ombudsman for Long-Term Care (OOLTC), Office of Ombudsman for Mental Health and Developmental Disabilities (OMHDD), Managed Care Ombudsman at the Department of Human Services (DHS), county-managed care advocates, or other relevant advocacy services; and	01470			

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01470	Continued From page 33 - a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. RN-G RN-G was hired August 1, 2023, to provide nursing services to residents. RN-G's employee record contained an EduCare transcript of RN-G's completed courses however, RN-G's employee record lacked the following required orientation topics: - an overview of chapter 144G; - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; - handling of emergencies and use of emergency services; - compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; - consumer advocacy services of the Office of Ombudsman for Long-Term Care (OOLTC), Office of Ombudsman for Mental Health and Developmental Disabilities (OMHDD), Managed Care Ombudsman at the Department of Human Services (DHS), county-managed care advocates, or other relevant advocacy services; - a review of the types of assisted living services the staff member will be providing and the facility's category of licensure; and - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.	01470			

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01470	Continued From page 34 On April 22, 2026, at 12:05 p.m., ALDIR/CNS-B stated ALDIR/CNS-B issued orientation training courses through EduCare which were completed by all employees prior to skills training and competency sign-off with ALDIR/CNS-B. ALDIR/CNS-B further stated ALDIR/CNS-B was aware of the required courses for orientation and ALDIR/CNS-B was unsure why the missing training was not completed. The licensee's undated 4.18 Employee General Orientation policy indicated upon hire and prior to performing any functions of the employee's position at [licensee], each new employee was oriented in accordance with state and federal regulations. The policy further indicated an employee was not to perform job duties before general and safety orientation was completed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470			
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;	01500			

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01500	Continued From page 35 (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and	01500			

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01500	Continued From page 36 involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure an employee received all the required content for annual training for each 12 months of employment for three of three employees (unlicensed personnel (ULP)-C, ULP-D, and registered nurse (RN)-G). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on April 20, 2026, at 12:04 p.m., assisted living director in residency/clinical nurse supervisor (ALDIR/CNS)-B stated the licensee was aware of required contents in an employee record. ULP-C ULP-C was hired June 1, 2024, to provide direct care services to residents at the assisted living with dementia care facility. ULP-C's employee record included 0.75 hours of annual education in 2026. ULP-C's record lacked eight hours of required annual education and did	01500			

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01500	Continued From page 37 not include the following required topics: - training on reporting of maltreatment of vulnerable adults under section 626.557; - review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; - effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; and - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. ULP-D ULP-D was hired February 21, 2025, to provide direct care services to residents. On April 21, 2026, at 7:26 a.m., the surveyor observed ULP-D assist R9 with ambulation and toileting. ULP-D's employee record included eight hours of annual education in 2026. ULP-D's record lacked the following required topic: review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures. RN-G RN-G was hired August 1, 2023, to provide	01500			

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01500	Continued From page 38 nursing services to residents. RN-G's employee record included zero hours of annual education in 2026. RN-G's record lacked including the following required topics: - training on reporting of maltreatment of vulnerable adults under section 626.557; - review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; - effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; - review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On April 22, 2026, at 11:51 a.m., ALDIR/CNS-B stated ALDIR/CNS-B issued annual education courses in January of every calendar year and expected the courses were completed by April 1st of each year. ALDIR/CNS-B further stated ALDIR/CNS-B was aware of the required annual coursework by following a list provided by	01500			

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NAME OF PROVIDER OR SUPPLIER COLLEENS CARING HANDS INC		STREET ADDRESS, CITY, STATE, ZIP CODE 2525 BEMIDJI AVENUE NORTH BEMIDJI, MN 56601			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01500	Continued From page 39 EduCare (online training software). ALDIR/CNS-B also stated ALDIR/CNS-B provided all available documentation from the requested employee files and was unsure why there was missing coursework. The licensee's 5.06 Annual Required Staff Training policy dated March 9, 2026, indicated all licensee staff who performed direct care services completed at least eight hours of annual training for each 12 months of employment. The policy further indicated the following training elements must be included every 12 months: - training on reporting of maltreatment of vulnerable adults under section 626.557; - review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; - effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; - review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and - principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.	01500			

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01500	Continued From page 40 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500			
01540 SS=F	144G.64 (a) (3) Training in Dementia, Mental Illness, and De- (3) for assisted living facilities with dementia care, direct-care staff must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, the staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure three of four employees (assisted living director in residency/clinical nurse supervisor	01540			

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01540	Continued From page 41 (ALDIR/CNS)-B, unlicensed personnel (ULP)-C, and registered nurse (RN)-G) received the required amount of dementia care training in the required time frame. Additionally, the licensee failed to ensure two of four employees (ULP-C and RN-G) received the required amount of mental illness and de-escalation training within the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living facility with dementia care (ALFDC) license effective August 1, 2025. During the entrance conference on April 20, 2026, at 12:04 p.m., ALDIR/CNS-B stated the licensee was aware of required contents in an employee record. DEMENTIA TRAINING ALDIR/CNS-B ALDIR/CNS-B was hired January 2, 2024, to provide nursing and leadership services to residents at the assisted living with dementia care facility. On April 20 through April 22, 2026, the surveyor observed ALDIR/CNS-B process medication	01540			

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01540	Continued From page 42 orders and assist with resident and employee requests. On April 22, 2026, at 12:00 p.m., ALDIR/CNS-B stated ALDIR/CNS-B was employed part-time (less than 32 hours per pay period) when hired however, ALDIR/CNS-B confirmed ALDIR/CNS-B had worked more than 80 hours during ALDIR/CNS-B's first eight months of employment for licensee. ALDIR/CNS-B's EduCare (online training software) transcript indicated ALDIR/CNS-B completed 7.75 hours of dementia related training as of September 1, 2024, indicating eight months had passed since ALDIR/CNS-B's date of hire. ULP-C ULP-C was hired June 1, 2024, to provide direct care services to residents at the assisted living with dementia care facility. On April 20, 2026, at 3:02 p.m., ALDIR/CNS-B stated ULP-C was employed full-time (32-40 hours per week) since being hired. ULP-C's EduCare transcript indicated ULP-C completed no hours of dementia related training as of June 22, 2024, indicating three weeks had passed since ULP-C's date of hire. ULP-C's EduCare transcript indicated eight hours was completed as of June 26, 2024. In addition, ULP-C's EduCare transcript indicated ULP-C lacked evidence of any annual dementia training in 2025 or 2026. RN-G RN-G was hired August 1, 2023, to provide nursing services to residents at the assisted living with dementia care facility.	01540			

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01540	Continued From page 43 On April 22, 2026, at 12:00 p.m., ALDIR/CNS-B stated RN-G was employed full-time at time of hire. RN-G's EduCare transcript indicated RN-G lacked completion of zero hours of dementia training in 2023. Furthermore, RN-G completed 0.75 hours in 2024, 6.25 hours in 2025, and 3.5 hours in 2026, of dementia related training. MENTAL ILLNESS/DE-ESCALATION TRAINING ULP-C ULP-C's EduCare transcript indicated ULP-C completed one hour of mental illness/de-escalation training on January 8, 2025. ULP-C's EduCare transcript lacked evidence which indicated ULP-C had completed two hours of mental illness or de-escalation training by July 1, 2025. RN-G RN-G's EduCare transcript indicated RN-G had completed zero hours of mental illness/de-escalation training as of the start of survey. RN-G's EduCare transcript lacked evidence which indicated RN-G had completed two hours of mental illness or de-escalation training by July 1, 2025. On April 22, 2026, at 12:00 p.m., ALDIR/CNS-B stated ALDIR/CNS-B was aware of dementia and mental illness training requirements as indicated in 144G statutes. ALDIR/CNS-B further stated ALDIR/CNS-B was unsure why assigned modules were not completed on-time.	01540			

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01540	Continued From page 44 The licensee's 5.03 Dementia Training policy dated May 2, 2024, indicated direct care employees completed eight hours of dementia training within 80 hours of the employment start date and two additional hours of training for every 12 months of employment thereafter. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540			
01880 SS=D	144G.71 Subd. 19 Storage of medications 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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one refrigerator storing medications maintained an acceptable temperature and medications were stored according to manufacturer's recommended temperature. 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).	01880			

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01880	Continued From page 45 The findings include: During the entrance conference on April 20, 2026, at 11:41 a.m., assisted living director in residency/clinical nurse supervisor (ALDIR/CNS)-B stated the licensee provided medication management services to residents at the facility. On April 20, 2026, at 3:08 p.m., the surveyor observed the medication refrigerator, located in the nursing office, with ALDIR/CNS-B. ALDIR/CNS-B stated the refrigerator does not have a thermometer in it at this time and daily temperature monitoring was not being completed. The medication refrigerator currently contained one unopened pen of R6's Ozempic (long-acting diabetic management injection). ALDIR/CNS-B further stated it was ALDIR/CNS-B's error for not replacing the thermometer and assuring daily temperature monitoring was completed to assure medication integrity was protected. The manufacturer's instructions for Ozempic dated October 2022, indicated to store unopened Ozempic in the refrigerator at 36 degrees F to 46 degrees F. Do not allow Ozempic to freeze. The licensee's 7.11 Medication Storage policy dated December 29, 2023, indicated medications managed by [licensee] were stored per manufacturer's directions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			

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01890	Continued From page 46	01890			
01890 SS=F	144G.71 Subd. 20 Prescription drugs 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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to monitor for expired medications in one of one medication storage compartment. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on April 20, 2026, at 11:41 a.m., assisted living director in residency/clinical nurse supervisor (ALDIR/CNS)-B stated the licensee provided medication management services to residents at the facility. On April 21, 2026, at 10:55 a.m., the surveyor observed the medication storage cabinet with unlicensed personnel (ULP)-E and observed the following:	01890			

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01890	Continued From page 47 - R2's acetaminophen 160 milligrams (mg)/ five milliliter (ml), partial bottle remained, expired February 2026; - R5's brimonidine tartrate/timolol maleate (decreases pressure in the eyes) 0.2%/0.5% ophthalmic solution, was labeled with an opened January 2, 2026, which indicated it would expire on January 29, 2026; - R5's brimonidine tartrate/timolol maleate 0.2%/0.5% ophthalmic solution, expired March 2026 per manufacturer date; - R7's olanzapine five mg, expired April 18, 2026, quantity 17 tablets remained; and - R8's quetiapine 25 mg, expired January 18, 2026, quantity eight- ½ tablets remained. On April 21, 2026, at 11:07 a.m., ULP-E stated ALDIR/CNS-B completed medication supply audits however, ULP-E was unsure how often the audits were completed. On April 21, 2026, at 11:43 a.m., ALDIR/CNS-B stated ALDIR/CNS-B stated ALDIR/CNS-B completed medication supply audits weekly and the above medications were missed in error. The manufacturer instructions for brimonidine tartrate 0.2% ophthalmic solution issued March 2016, lacked instruction for when to discard after opening, however, the manufacturer directions for timolol maleate 0.5% issued June 2020, directed to discard remaining contents four weeks after being opened. The licensee's 7.23 Medication Disposal policy dated December 29, 2023, indicated expired medications managed by [licensee] were disposed of according to the accepted practices of the Minnesota Board of Pharmacy.	01890			

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01890	Continued From page 48 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care must meet the requirements of section 144G.45 and the following additional requirements: (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 (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to	02040			

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02040	Continued From page 49 affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated April 20, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	02040			
02160 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (a) In addition to the minimum services required in section 144G.41, an assisted living facility with dementia care must also provide the following services: (1) assistance with activities of daily living that address the needs of each resident with dementia due to cognitive or physical limitations. These services must meet or be in addition to the requirements in the licensing rules for the facility. Services must be provided in a person-centered manner that promotes resident choice, dignity, and sustains the resident's abilities; (2) nonpharmacological practices that are person-centered and evidence-informed; (3) services to prepare and educate persons living with dementia and their legal and designated representatives about transitions in care and ensuring complete, timely communication between, across, and within settings; and (4) services that provide residents with choices for meaningful engagement with other facility residents and the broader community.	02160			

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02160	Continued From page 50 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide activities of daily living (ADLs) in a way that was person-centered and promoted resident choice, dignity, and sustains the resident's abilities for three of three (R2, R4, and R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On April 20, 2026, during the entrance conference from 11:21 a.m. through 12:30 p.m., owner/unlicensed personnel (O/ULP-A) and assisted living director in residency/clinical nurse supervisor (ALDIR/CNS-B), indicated they were familiar with 144G requirements. On April 21, 2026, from 8:22 a.m. through 8:27 a.m., the surveyor observed ULP-F assisting R2, R4, and R5 with eating breakfast. The surveyor observed all three of the resident's plates to have waffle, sausage patty, and apple sauce cut into small, bite sized pieces, and everything stirred together before being offered to the resident. R2's diagnoses included Alzeheimer's dementia, esophageal reflux, and diverticulosis (formation of small pouches in the colon).	02160			

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02160	Continued From page 51 R2's service plan dated August 27, 2025, indicated R2 received assistance with dressing, grooming, bathing, toileting, medication management, eating assistance with three meals daily and snacks as needed, laundry, and housekeeping. R2's assessment dated March 2, 2026, indicated R2 enjoys to eat raisin bran cerial for breakfast, could feed self, and finger foods were easier for R2. There was no indication of requiring altered texture to diet. R2's record lacked evidence an altered texture diet was ordered for R2. On April 21, 2026, at 11:22 a.m., ALDIR/CNS-B stated R2 was a good eater and didn't require a mixed diet. ALDIR/CNS-B indicated she was not aware staff were mixing food like that, and wouldn't want her food mixed, adding "I'm not happy about it, and it is a dignity concern." On April 22, 2026, at 8:30 a.m., the surveyor observed breakfast. All residents were served oatmeal with peaches and cream on top. The peaches were of blended texture and in the kitchen, a food processor was observed with blended peaches inside. On April 22, 2026, at 11:35 a.m., ALDIR/CNS-B stated peaches should not have been blended for breakfast, as canned peaches were mashable with a fork. ALDIR/CNS-B stated she had spoken to some staff already, and was unsure why altering textures of foods continued. The licensee's 3.03 ALDC (assisted living dementia care) Dementia Care Philosophy policy	02160			

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NAME OF PROVIDER OR SUPPLIER COLLEENS CARING HANDS INC		STREET ADDRESS, CITY, STATE, ZIP CODE 2525 BEMIDJI AVENUE NORTH BEMIDJI, MN 56601			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
02160	Continued From page 52 dated March 9, 2026, indicated the care provided to those with dementia must be individualized and reflected the individual's concerns, life history, meaning, relationships, emotions, thoughts, current needs, strengths, and preferences. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02160			



Bemidji District Office
Minnesota Department of Health
705 5th St NW, Suite A
Bemidji, MN 56601
Phone: 651-201-4500

Food & Beverage Inspection Report

Page: 1

Establishment Info

Colleens Caring Hands Inc
2525 BEMIDJI AVENUE NORTH
Bemidji, MN 56601
Beltrami County
Parcel:

Phone:
colleenscaringhands@yahoo.com

License Info

License: HFID 30648
Colleen Hill-Kjos
Risk:
License:
Expires on:
CFPM: Alicia Lauderbaugh
CFPM #: 25564; Exp: 11/12/2028

Inspection Info

Report Number: F3822261042
Inspection Type: Full - Single
Date: 4/21/2026 Time: 11:36:27 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 1
Delivery:

New Order: 2-100 Supervision

2-102.12DMN Priority Level: Priority 3 CFP#: 2

MN Rule 4626.0033D Post the certified food protection manager certificate.

COMMENT: POST ALICIA'S STATE CERTIFIED FOOD MANAGER CERTIFICATE IN KITCHEN.

Comply By: 4/28/2026 Originally Issued On: 4/21/2026

Food & Beverage General Comment

INSPECTION FOR HRD SURVEY.

SAME DAY SERVICE. EGGS AND MEAT FULLY COOKED.

OBSERVED PROPER GLOVE USE.

TWO REFRIGERATORS/FREEZERS IN BACK OFFICE.

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 Bemidji District Office inspection report number F3822261042 from 4/21/2026

Colleen Hill-Kjos
Owner

Dave Kaufman,
Public Health Sanitarian 3
218-308-2113
david.kaufman@state.mn.us



Bemidji District Office
Minnesota Department of Health
705 5th St NW, Suite A
Bemidji, MN 56601

Temperature Observations/Recordings

Page: 1

Establishment Info

Colleens Caring Hands Inc
Bemidji
County/Group: Beltrami County

Inspection Info

Report Number: F3822261042
Inspection Type: Full
Date: 4/21/2026
Time: 11:36:27 AM

Food Temperature: Product/Item/Unit: ; Temperature Process: Cooking

Location: Oven at 188 Degrees F.

Comment: PORK CHOPS

Violation Issued?: No

Equipment Temperature: Product/Item/Unit: ; Temperature Process: Cold-Holding

Location: Upright Cooler at 41 Degrees F.

Comment:

Violation Issued?: No



Bemidji District Office
Minnesota Department of Health
705 5th St NW, Suite A
Bemidji, MN 56601

Sanitizer Observations/Recordings

Page: 1

Establishment Info

Colleens Caring Hands Inc
Bemidji
County/Group: Beltrami County

Inspection Info

Report Number: F3822261042
Inspection Type: Full
Date: 4/21/2026
Time: 11:36:27 AM

Sanitizing Chemical: Product: Chlorine; **Sanitizing Process:** Spray Bottle

Location: Equal To 200 PPM

Comment:

Violation Issued?: No

Sanitizing Chemical: Product: Quaternary Ammonia; **Sanitizing Process:** Spray Bottle

Location: Equal To 200 PPM

Comment:

Violation Issued?: No

Sanitizing Equipment: Product: Hot Water; **Sanitizing Process:** Dish Machine

Location: Equal To 160 Degrees F.

Comment:

Violation Issued?: No

Minnesota (MDH) Version EH Manager; RPT: F3822261042		Food Establishment Inspection Report		Page 1 of 1	
 Bemidji District Office Minnesota Department of Health 705 5th St NW, Suite A Bemidji, MN 56601		No. of Risk Factor/Intervention/Violations		1	Date: 4/21/2026
		No. of Repeat Risk Factor/Intervention/Violations			Time: 11:36:27 AM
		Score (optional)			Dur: min
Establishment: Colleens Caring Hands Inc		Address: 2525 BEMIDJI AVENUE NORTH		City/State: Bemidji, MN	Zip: 56601
License/Permit #: HFID 30648		Permit Holder: Colleen Hill-Kjos		Purpose of Inspection: Full	Est. Type: Risk Category:
FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS					
Designated compliance status (IN, OUT, N/O, N/A) for each numbered item					
IN=in compliance OUT=not in compliance N/O=not observed N/A=not applicable					
Mark "X" in appropriate box for COS and/or R					
COS=corrected on-site during inspection R=repeat violation					
Compliance Status		COS	R		
Supervision					
1	IN	Person in charge present, demonstrate knowledge and performs duties			
2	OUT	Certified Food Protection Manager			
Employee Health					
3	IN	knowledge, responsibilities, and reporting			
4	IN	Proper use of restriction and exclusion			
5	IN	Response to vomiting, diarrheal events			
Good Hygienic Practices					
6	IN	Proper eating, tasting, drinking, tobacco use			
7	IN	No discharge from eyes, nose, and mouth			
Preventing Contamination by Hands					
8	IN	Hands clean and properly washed			
9	IN	No bare hand contact with RTE foods, alternatives			
10	IN	Adequate handwashing sinks supplied and access			
Approved Source					
11	IN	Food obtained from approved source			
12	N/O	Food Received at proper temperature			
13	IN	Food in good condition, safe & unadulterated			
14	N/A	Records available: shellstock tags, parasite dest.			
Protection From Contamination					
15	IN	Food separated and protected			
16	IN	Food-contact surfaces; cleaned & sanitized			
17	IN	Proper Disposition of returned, previously served, reconditioned,& unsafe food			
GOOD RETAIL PRACTICES					
Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.					
Mark "X" or OUT in box if numbered item is not in compliance Mark "X" in appropriate box for COS and/or R COS=corrected on-site during inspection R=repeat violation					
Compliance Status		COS	R		
Safe Food and Water					
30	N/A	Pasteurized eggs used where required			
31		Water & ice from approved source			
32	N/A	Variance obtained for specialized processing methods			
Food Temperature Control					
33		Proper cooling methods used; adequate equipment for temperature control			
34	N/A	Plant food properly cooked for hot holding			
35	N/O	Approved thawing methods used			
36		Thermometers provided & accurate			
Food Identification					
37		Food properly labeled; original container			
Prevention of Food Contamination					
38		Insects, rodents, & animals not present; no unauthorized person			
39		Contamination prevented during food prep, storage, & display			
40		Personal cleanliness			
41		Wiping cloths: properly used & stored			
42		Washing fruits & vegetables			
Person in Charge (signature)					
Inspector (signature) 					
Follow-up: Follow-up Date:					
Compliance Status		COS	R		
Time/Temperature Control for Safety					
18	IN	Proper cooking time & temperatures			
19	N/A	Proper reheating procedures for hot holding			
20	N/A	Proper cooling time and temperature			
21	N/A	Proper hot holding temperatures			
22	IN	Proper cold holding temperatures			
23	IN	Proper date marking & disposition			
24	N/A	Time as public health control;procedures & record			
Consumer Advisory					
25	N/A	Consumer advisory provided for raw or undercooked foods			
Highly Susceptible Populations					
26	N/A	Pasteurized foods used; prohibited foods not offered			
Food/Color Additives and Toxic Substances					
27	N/A	Food additives; approved & properly used			
28	IN	Toxic substances properly identified;stored;used			
Conformance with Approved Procedures					
29	N/A	Compliance with variance, specialized processes & HACCP plan			
Risk factors are improper practices or procedures identified as the most prevalent contributing factors of foodborne illness or injury. Public Health interventions are control measures to prevent foodborne illness or injury					

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL30648016-0	Date: April 20, 2026
Facility Name: Colleen’s Caring Hands	
Facility Address: 2525 Bemidji Ave N, Bemidji, MN 56601	

☒ TAG IDENTIFICATION: 0775

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]
2. Building fire alarm systems shall be inspected and tested annually. [Minn. Stat. 144G.45 subd. 2; MSFC 901.6.1]

Comments: When asked for a copy of the most recent fire alarm report owner (O)-B stated that they were not aware of any fire alarm test being completed and did not have any report to provide.

3. Fire detection and alarm systems, emergency alarm systems, gas detection systems, fire-extinguishing systems, mechanical smoke exhaust systems and smoke and heat vents shall be maintained in an operative condition at all times and shall be replaced or repaired where defective. [Minn. Stat. 144G.45 subd. 2; MSFC 901.6]

Comments: There was an amber light on what O-B indicated was their fire alarm panel. There was no read out on the digital display, or on any of the lights on the panel face. O-B stated that they did not know what the amber light indicated. Amber lights on normal fire alarm panels indicate a trouble and/or supervisory signal indicating that the system is not operating as intended. Have a licensed contractor investigate the amber light on the fire alarm panel and repair or replace as needed.

4. In buildings protected by automatic sprinklers or automatic fire detectors, suspended or removable ceiling tiles shall be maintained in place to prevent the delay in sprinkler or detector activation. [Minn. Stat. 144G.45 subd. 2; MSFC 901.11]

Comments: Inside of the craft closet there were ceiling tiles that were hanging down.

5. Where smoking is permitted, suitable noncombustible ashtrays or match receivers shall be provided on each table and at other appropriate locations. [Minn. Stat. 144G.45 subd. 2; MSFC 310.6]

Comments: On both wooden decks on the east side of the facility, there were cigarettes being discarded into plastic containers.

☒ **TAG IDENTIFICATION: 0790**

SCOPE/ SEVERITY: Level 1; Widespread

TIME PERIOD OF CORRECTION: Two (2) days

1. Portable fire extinguishers installed and maintained to MN State Fire Code. [Minn. Stat. 144G.45 subd.2]

Comments: The fire extinguishers throughout the facility were lacking documentation of 30 day checks.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Twenty One (21) days

1. The physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment are in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. [Minn. Stat. 144G.45 subd.2]

Comments: During the tour, after observing stained and water damaged ceilings, the surveyor asked O-B if there was a roof leak. O-B stated that the roof did leak, and they have been working with their insurance company to have it repaired.

Stained and water damaged ceilings were observed in the shower room, and bathroom 1. O-B stated that it was due to the roof leak and would be repaired after the roof was repaired.

There was a rotted deck board on the northeast deck. O-B stated that they were not aware of the rotted deck board and believed it happened over the winter.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 3; Widespread

TIME PERIOD OF CORRECTION: Twenty One (21) days

1. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include fire protection procedures necessary for residents. [Minn. Stat. 144G.45 subd.2]

Comments: The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency.

2. Employees of assisted living facilities shall receive training on the fire safety and evacuation plans (FSEP) upon hiring and at least twice per year thereafter. [Minn. Stat. 144G.45 subd.2]

Comments: O-B stated that they did not have any documentation of staff receiving training on the FSEP.

3. 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. [Minn. Stat. 144G.45 subd.2]

Comments: O-B stated that residents had not received any training on the facility's FSEP.

4. Evacuation drills are required for employees 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. [Minn. Stat. 144G.45 subd.2]

Comments: O-B provided documentation of fire drills for January 2026, and March 2026. When the surveyor requested drill documentation for calendar year 2025, O-B stated that drills were completed, but that they did not have any documentation due to a small fire that had happened in the office on July 1, 2025. The surveyor asked if all drill records were destroyed in the fire. O-B stated that no documents were destroyed, but that they were removed from the office for cleaning, and they were unable to locate any drill records from 2025.

☒ **TAG IDENTIFICATION: 2040**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Twenty One (21) days

1. An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and have a safety risk assessment performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm. [Minn. Stat. 144G.81 subd.1]

Comments: On April 20, 2026, at 2:25 p.m. the surveyor requested documentation that a safety risk assessment was completed on and around the facility along with mitigating factors. O-B stated that they did not have one and would have staff work on making one.