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

# NOTICE OF PROVISIONAL EXTENSION AND CONDITIONAL LICENSE

Electronically Delivered

June 11, 2026

Licensee
Colfax Careview Inc
8332 Colfax Avenue South
Bloomington, MN 55420

RE: Provisional Conditional License Number 421794
Health Facility Identification Number (HFID) 42025
Project Number SL42025015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 10, 2026, for the purpose of assessing compliance with state licensing statutes. Based on the survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.16, Subd. 3(b)(2), MDH is extending the provisional license for 60-days and applying conditions necessary to bring the facility into substantial compliance. The provisional license extension and conditions are due to expire **August 10, 2026.**

**STATE CORRECTION ORDERS**
The enclosed State Form documents the state correction orders. MDH documents state 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.

MDH may assess fines based on the level and scope of the orders outlined below. The total amount of **potential** fines that may be assessed related to these correction orders is $1,000.00. **MDH is not imposing these fines against your provisional license at this time.**

**St - 0 - 0330 - 144g.30 Subd. 4 - Information Provided By Facility - $500.00**
**St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00**

**DOCUMENTATION OF ACTION TO COMPLY**
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the provisional licensee must document actions taken to comply with the correction orders and immediately correct any reissued orders outlined on the state form; however, plans of correction are not required to be submitted for approval. **If corrections are not made, MDH may impose fines as described above and in accordance with Minnesota Statutes 144G.**

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 MDH 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.

**CONDITIONAL LICENSE ISSUED:**
MDH will issue Colfax Careview Inc a conditional provisional assisted living facility license for 60 calendar days from the date of this notice. At an unannounced point in time, within the 60 calendar days, MDH will conduct a

follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if Colfax Careview Inc is in substantial compliance.

The following conditions apply on the conditional provisional assisted living facility license:

a. **No new substantiated maltreatment allegations:** If any new investigations begin in the conditional provisional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the provisional license.

b. **No new admissions:** Colfax Careview Inc will not admit any new residents under its conditional provisional assisted living facility license until MDH removes the "no new admissions" condition. Colfax Careview Inc must provide the Department:

   i. A list of the names and birthdates of any individuals Colfax Careview Inc is currently in the process of admitting. These individuals will be able to continue the admittance process.

   ii. A list of all current residents including:
      1. Name and birthdate of each resident
      2. Current payment source for services
      3. If Elderly Waiver, the name and contact information of the care coordinator/case manager
      4. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative

c. **Monitoring visits:** MDH may make unannounced monitoring visits to assess the progress of Colfax Careview Inc to correct the violations cited during the survey as well as to determine the overall practice of Colfax Careview Inc in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive provisional licensed assisted living services. The OOLTC will share their findings with MDH.

d. **Follow-up survey:** At the time of the follow-up survey, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the provisional license if MDH identifies any level 3, 4 or 5 violations or widespread care related violations.

e. **Corrective Action Plan:** Colfax Careview Inc will develop and work within a corrective action plan (CAP). **Please submit the CAP via email at Jess.Schoenecker@state.mn.us no later than July 11, 2026.** The CAP is a working document that includes at least the following information:
   i. A statement of the concern
   ii. A description of what will happen to correct the concern
   iii. A target date for when each correction will be complete
   iv. Who is responsible to make sure it happens
   v. Current status of correction work

vi. Description of a plan to monitor and ensure ongoing substantial compliance for each corrected order

**RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL PROVISIONAL LICENSE PERIOD:**
MDH will determine if Colfax Careview Inc is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 60-day conditional provisional license period. If MDH determines Colfax Careview Inc is in substantial compliance on the follow up survey, MDH will remove the conditions and grant the assisted living facility license to Colfax Careview Inc. If MDH determines Colfax Careview Inc is not in substantial compliance, MDH may deny the license pursuant to Minn. Stat. § 144G.16, Subd. 3 (b) (2).

**REQUEST FOR RECONSIDERATION:**
Pursuant to Minn. Stat. §144G.16, Subd. 4, if a provisional licensee whose assisted living facility license has been denied, or extended with conditions, disagrees with the action taken against the provisional license under this section, the provisional licensee may request a reconsideration no later than 15 calendar days after provisional licensee receives notice of the action. **This is your only ability to request a reconsideration under this enforcement action.**

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

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 Jess Schoenecker directly at: 651-201-3789 or email at: Jess.Schoenecker@state.mn.us.

Sincerely,

Rick Michals

Rick Michals, J.D.
**Executive Regional Operations Manager**
**Minnesota Department of Health**
**Health Regulation Division**

HHH

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 42025 | A. BUILDING: _____ B. WING _____ | 04/10/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COLFAX CAREVIEW INC | 8332 COLFAX AVE S BLOOMINGTON, MN 55420 |

| (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<br><br>*****ATTENTION*****<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.<br><br>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.<br><br>INITIAL COMMENTS:<br><br>SL42025015<br><br>On April 6, 2026, through April 10, 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 3 residents receiving services under the Provisional Assisted Living Facility license. | 0 000 | Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>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. | |
| 0 330 SS=F | 144G.30 Subd. 4 Information provided by facility<br><br>(a) The assisted living facility shall provide | 0 330 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 42025 | A. BUILDING: _____ B. WING _____ | 04/10/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COLFAX CAREVIEW INC | 8332 COLFAX AVE S BLOOMINGTON, MN 55420 |

| (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 |
|---|---|---|---|---|
| 0 330 | Continued From page 1<br><br>accurate and truthful information to the department during a survey, investigation, or other licensing activities.<br>(b) Upon request of a surveyor, assisted living facilities shall within a reasonable period of time provide a list of current and past residents and their legal representatives and designated representatives that includes addresses and telephone numbers and any other information requested about the services to residents.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to provide the Minnesota Department of Health (MDH) with accurate and truthful information during a survey. This had the potential to affect all residents.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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).<br><br>The findings include:<br><br>On April 6, 2026, at 7:41 a.m., the surveyor emailed the licensee a state evaluations survey notification letter to the licensee's email on file with the Minnesota Department of Health (MDH).<br><br>On April 6, 2026, at 8:05 a.m., the surveyor received an email from the individual listed as the licensed assisted living director on file with MDH. The individual stated they were unaware of whom | 0 330 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 42025 | A. BUILDING: _____ B. WING _____ | 04/10/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COLFAX CAREVIEW INC | 8332 COLFAX AVE S BLOOMINGTON, MN 55420 |

| (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 |
|---|---|---|---|---|
| 0 330 | Continued From page 2<br><br>the licensee was and that they had never been employed with the licensee.<br><br>On April 6, 2026, at 9:25 a.m., the surveyor received an email from the licensee that the individual that was listed as the licensed assisted living director (LALD) on file with MDH had declined the position with the licensee. The email was signed with the business name of the licensee and lacked an individual's name for the signature.<br><br>On April 6, 2026, at 10:22 a.m., during a facility tour, the surveyor observed a posting of the LALD license which was a different name than what was listed on file with MDH.<br><br>On April 6, 2026, at 10:31 a.m., during the entrance conference, clinical nurse supervisor (CNS)-A the licensee had not notified MDH of the new LALD hired on October 15, 2025.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 330 | | |
| 0 460 SS=F | 144G.41 Subdivision 1 Minimum requirements<br><br>(5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week;<br>(6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract;<br>(7) permit residents access to food at any time;<br>(8) allow residents to choose the resident's visitors and times of visits;<br>(9) allow the resident the right to choose a | 0 460 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 42025 | A. BUILDING: _____ B. WING _____ | 04/10/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COLFAX CAREVIEW INC | 8332 COLFAX AVE S BLOOMINGTON, MN 55420 |

| (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 |
|---|---|---|---|---|
| 0 460 | Continued From page 3<br><br>roommate if sharing a unit;<br>(10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit;<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week. This had the potential to affect all current residents.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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).<br><br>The findings include:<br><br>On April 6, 2026, at approximately 10:00 a.m., during a facility tour, the surveyor observed the facility was a two-level home with a main floor and lower level. The surveyor also observed no pendants, call light systems, or means to request assistance were available in the residents' rooms.<br><br>On April 6, 2026, at approximately 10:30 a.m., during the entrance conference, clinical nurse | 0 460 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 42025 | A. BUILDING: _____ B. WING _____ | 04/10/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COLFAX CAREVIEW INC | 8332 COLFAX AVE S BLOOMINGTON, MN 55420 |

| (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 |
|---|---|---|---|---|
| 0 460 | Continued From page 4<br><br>supervisor (CNS)-A stated the licensee did not have a call light or pendant system the residents could use to summon staff as their current call button system they were using was not working. CNS-A also stated residents would verbally call out to the licensee's staff or leave their rooms and locate a staff member, if they needed assistance. CNS-A further stated the licensee staffed an employee 24 hours per day and that someone was always available to hear if a resident was needing assistance. CNS-A stated because the home was a smaller home, the licensee did feel it was appropriate for the residents to yell out to staff if they needed assistance because the staff would be able to hear them from any area in the home.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 460 | | |
| 0 470 SS=F | 144G.41 Subdivision 1 Minimum requirements<br><br>(11) develop and implement a staffing plan for determining its staffing level that:<br>(i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility;<br>(ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and<br>(iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility;<br>(12) ensure that one or more persons are | 0 470 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 42025 | A. BUILDING: _____ B. WING _____ | 04/10/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COLFAX CAREVIEW INC | 8332 COLFAX AVE S BLOOMINGTON, MN 55420 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 0 470 | Continued From page 5<br><br>available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be:<br>(i) awake;<br>(ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time;<br>(iii) capable of communicating with residents;<br>(iv) capable of providing or summoning the appropriate assistance; and<br>(v) capable of following directions;<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure the registered nurse (RN) reviewed the staffing plan at least twice per year. This had the potential to affect all residents, staff, and visitors.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or 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).<br><br>The findings include:<br><br>The licensee held an assisted living license and was licensed for a capacity of five residents, with a current census of three residents.<br><br>During the entrance conference on April 6, 2026, at 10:30 a.m., clinical nurse supervisor (CNS)-A | 0 470 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 42025 | A. BUILDING: _____ B. WING _____ | 04/10/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COLFAX CAREVIEW INC | 8332 COLFAX AVE S BLOOMINGTON, MN 55420 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 0 470 | Continued From page 6<br><br>stated the licensee was familiar with current minimum assisted living requirements.<br><br>The licensee's undated Direct Care Staffing Plan did not indicate who had developed and implemented the written staffing plan. The staffing plan also lacked documentation it had been reviewed at least twice per year.<br><br>On April 6, 2026, at 1:12 p.m., CNS-A stated they had not reviewed the staffing plan at least twice per year as CNS-A stated he was not aware of this requirement.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 470 | | |
| 0 480 SS=F | 144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services<br><br>(a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626.<br>(b) For an assisted living facility with a licensed capacity of ten or fewer residents:<br>(1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation;<br>(2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed | 0 480 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 42025 | A. BUILDING: _____ B. WING _____ | 04/10/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COLFAX CAREVIEW INC | 8332 COLFAX AVE S BLOOMINGTON, MN 55420 |

| (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 |
|---|---|---|---|---|
| 0 480 | Continued From page 7<br>unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570;<br>(3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage;<br>(4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink;<br>(5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition;<br>(6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and<br>(7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure food was | 0 480 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 42025 | A. BUILDING: _____ B. WING _____ | 04/10/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COLFAX CAREVIEW INC | 8332 COLFAX AVE S BLOOMINGTON, MN 55420 |

| (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 |
|---|---|---|---|---|
| 0 480 | Continued From page 8<br><br>prepared and served according to the Minnesota Food Code.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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).<br><br>The findings include:<br><br>Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated April 7, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.<br><br>TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates. | 0 480 | | |
| 0 490 SS=F | 144G.41 Subdivision 1b Minimum requirements; other required services<br><br>All assisted living facilities must offer to provide or make available the following services to residents:<br>(1) weekly housekeeping;<br>(2) weekly laundry service;<br>(3) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for | 0 490 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 42025 | A. BUILDING: _____ B. WING _____ | 04/10/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COLFAX CAREVIEW INC | 8332 COLFAX AVE S BLOOMINGTON, MN 55420 |

| (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 |
|---|---|---|---|---|
| 0 490 | Continued From page 9<br><br>providing this assistance;<br>(4) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance;<br>(5) provide culturally sensitive programs; and<br>(6) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to have a daily program of social and recreational activities based on individual and group interests, physical, mental, and psychosocial needs, that created opportunities for active participation in the community at large. This had the potential to affect all residents of the facility.<br><br>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 client'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 clients).<br><br>The findings include:<br><br>On April 6, 2026, at approximately 10:00 a.m., | 0 490 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 42025 | A. BUILDING: _____ B. WING _____ | 04/10/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COLFAX CAREVIEW INC | 8332 COLFAX AVE S BLOOMINGTON, MN 55420 |

| (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 |
|---|---|---|---|---|
| 0 490 | Continued From page 10<br><br>during a facility tour, the surveyor observed no schedule was posted to indicate daily activities.<br><br>During entrance conference on April 6, 2026, at approximately 10:30 a.m., clinical nurse supervisor (CNS)-A stated the licensee did not have a daily schedule of activities for residents. CNS-A stated they did not have a schedule or necessarily offer social and recreational activities every day, because residents decline to participate and have independent activities.<br><br>During the course of the survey from April 6, 2026, to April 10, 2026, the surveyor did not observe the licensee's staff provide any social or recreational activities to residents. Residents were observed to be sitting in the common area with their eyes closed, in their rooms with their doors shut, or outside smoking independently.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 490 | | |
| 0 510 SS=F | 144G.41 Subd. 3 Infection control program<br><br>(a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control.<br>(b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities.<br>(c) The facility must maintain written evidence of | 0 510 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 42025 | A. BUILDING: _____ B. WING _____ | 04/10/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COLFAX CAREVIEW INC | 8332 COLFAX AVE S BLOOMINGTON, MN 55420 |

| (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 |
|---|---|---|---|---|
| 0 510 | Continued From page 11<br>compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure infection control standards were followed for one of one unlicensed personnel ((ULP)-B) providing food preparation for resident meals. This had the potential to affect all residents.<br><br>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 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).<br><br>The findings include:<br><br>During observation on April 6, 2026, at 12:25 p.m., ULP-B was in the kitchen and was speaking with R2. ULP-B proceeded to begin the process of preparing lunch for R3. ULP-B removed the package of chicken from the kitchen refrigerator. ULP-B proceeded to open a kitchen cabinet and obtain seasoning bottles and a bowl. ULP-B placed the chicken into the bowl and began to open the containers of seasoning and sprinkled the seasonings onto the chicken. ULP-B then obtained a saucepan from the cupboard, closed the cupboard door, placed the saucepan on the kitchen stove, and obtained a bottle of cooking oil and placed the oil into the saucepan. ULP-B then went to the kitchen counter, obtained the bowl of chicken and a cooking utensil, and placed the contents of the chicken into the saucepan. | 0 510 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 42025 | A. BUILDING: _____ B. WING _____ | 04/10/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COLFAX CAREVIEW INC | 8332 COLFAX AVE S BLOOMINGTON, MN 55420 |

| (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 |
|---|---|---|---|---|
| 0 510 | Continued From page 12<br><br>ULP-B placed the utensil into the saucepan and began stirring the chicken around. ULP-B then walked to the kitchen outside door while holding the kitchen utensil with and proceeded to open the door with their right hand. ULP-B returned to the kitchen stove and placed the kitchen utensil back into the saucepan and continued to cook the chicken. ULP-B obtained a seasoning container and sprinkled the seasonings into the saucepan using their right hand. When ULP-B had completed cooking the chicken, ULP-B turned off the stove and removed the saucepan from the stove burner. ULP-B placed the cooked chicken into an unused bowl and proceeded to wash the saucepan in the kitchen sink. At no time during meal preparation was ULP-B was observed perfoming hand hygiene including washing their hands with soap and water or using any hand sanitizer.<br><br>During interview on April 6, 2026, at 12:50 p.m., clinical nurse supervisor (CNS)-A stated all staff were educated on hand washing during orientation. CNS-A also stated ULP-B would need to be re-educated regarding performing hand hygiene during food preparation.<br><br>The licensee's undated infection control policy indicated staff should was hands before preparing food.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Two (2) days | 0 510 | | |
| 0 550 SS=F | 144G.41 Subd. 7 Resident grievances; reporting maltreatment | 0 550 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 42025 | A. BUILDING: _____ B. WING _____ | 04/10/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COLFAX CAREVIEW INC | 8332 COLFAX AVE S BLOOMINGTON, MN 55420 |

| (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 |
|---|---|---|---|---|
| 0 550 | Continued From page 13<br><br>All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to post the required information related to the grievance procedure and contact information for the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances and the contact information for the Office of Ombudsman for Long-Term Care (OOLTC) and the Office of Ombudsman for Mental Health and Developmental Disabilities (OOMHDD). This had the potential to affect all the licensee's current residents, staff, and visitors.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or 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 | 0 550 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 42025 | A. BUILDING: _____ B. WING _____ | 04/10/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COLFAX CAREVIEW INC | 8332 COLFAX AVE S BLOOMINGTON, MN 55420 |

| (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 |
|---|---|---|---|---|
| 0 550 | Continued From page 14<br><br>problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>On April 6, 2026, at approximately 10:00 a.m., during a facility tour, the common areas shared by residents, staff, and visitors lacked a posting of the grievance procedure to include the name, telephone number, and e-mail contact information for the individuals who were responsible for handling resident grievances. The licensee did have a binder on the top shelf of the desk area next to the entrance. This binder included blank complaint forms that a person could complete. There was no documentation of the grievance procedure in this binder.<br><br>On April 6, 2026, at approximately 11:05 a.m., clinical nurse supervisor (CNS)-A acknowledged the required content was not posted in the common areas. CNS-A stated it was an oversight and it had been posted. CNS-A stated one of the residents becomes agitated at times and tears off paperwork that was posted on the licensee's walls or bulletin board.<br><br>The licensee's Grievance policy dated August 1, 2021, indicated the licensee would post the grievance procedure in the facility.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 550 | | |
| 0 570 SS=C | 144G.42 Subdivision 1 Display of license | 0 570 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 42025 | A. BUILDING: _____ B. WING _____ | 04/10/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COLFAX CAREVIEW INC | 8332 COLFAX AVE S BLOOMINGTON, MN 55420 |

| (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 |
|---|---|---|---|---|
| 0 570 | Continued From page 15<br><br>The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to display the original current license at the main entrance of the assisted living facility as required. This had the potential to affect all residents, staff, and visitors.<br><br>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 potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>The licensee held an assisted living license effective August 5, 2025, with an expiration date of August 5, 2026.<br><br>On April 6, 2026, at 10:10 a.m., during the facility tour with clinical nurse supervisor (CNS)-A and unlicensed personnel (ULP)-B, the surveyor observed the facility's main entrance lead into a common living area. The surveyor also observed the licensee had posted a current assisted living facility license in the facility's community living room area bulletin board next to the hallway the licensee's resident's rooms. The common living area was located to the left side of the home from the main entrance.<br><br>On April 6, 2026, at 10:45 a.m., CNS-A | 0 570 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 42025 | A. BUILDING: _____ B. WING _____ | 04/10/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COLFAX CAREVIEW INC | 8332 COLFAX AVE S BLOOMINGTON, MN 55420 |

| (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 |
|---|---|---|---|---|
| 0 570 | Continued From page 16<br><br>acknowledged the location of the licensee's posted license and stated they thought the licensee's assisted living license was displayed in the correct area. CNS-A also stated they were unaware that the license should be posted by the main entrance.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 570 | | |
| 0 640 SS=F | 144G.42 Subd. 7 Posting information for reporting suspected c<br><br>The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by:<br>(1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility;<br>(2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and<br>(3) providing reasonable accommodations with information and notices in plain language.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review the licensee failed to support protection and safety by not posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC). This had the potential to affect all residents, staff, and visitors.<br><br>This practice resulted in a level two violation (a | 0 640 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 42025 | A. BUILDING: _____ B. WING _____ | 04/10/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COLFAX CAREVIEW INC | 8332 COLFAX AVE S BLOOMINGTON, MN 55420 |

| (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 |
|---|---|---|---|---|
| 0 640 | Continued From page 17<br><br>violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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).<br><br>The findings include:<br><br>On April 6, 2026, at 10:00 a.m., during a facility tour, the surveyor did not observe information or a reporting number for MAARC posted in the common areas of the facility.<br><br>On April 6, 2026, at 11:26 a.m., clinical nurse supervisor (CNS)-A stated they believed they had posted the MAARC information in the common area however, R2 would get upset and remove the paperwork from the walls when they were upset. CNS-A stated staff had not replaced the required paperwork on the walls after R2 removed it.<br><br>The licensee's Vulnerable Adult Maltreatment - Prevention & Reporting policy dated January 1, 2025, indicated the licensee would post information and the reporting number for MAARC.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 640 | | |
| 0 650 SS=D | 144G.42 Subd. 8 (a) Staff records<br><br>(a) The facility must maintain current records of | 0 650 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 42025 | A. BUILDING: _____ B. WING _____ | 04/10/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COLFAX CAREVIEW INC | 8332 COLFAX AVE S BLOOMINGTON, MN 55420 |

| (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 |
|---|---|---|---|---|
| 0 650 | Continued From page 18<br><br>each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation:<br>(1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules;<br>(2) records of orientation, required annual training and infection control training, and competency evaluations;<br>(3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision;<br>(4) documentation of annual performance reviews that identify areas of improvement needed and training needs;<br>(5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and<br>(6) documentation of the background study as required under section 144.057.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed supervision of unlicensed personnel (ULP) within 30 calendar days of beginning to provide delegated tasks for one of one unlicensed personnel ((ULP)-B).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 | 0 650 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 42025 | A. BUILDING: _____ B. WING _____ | 04/10/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COLFAX CAREVIEW INC | 8332 COLFAX AVE S BLOOMINGTON, MN 55420 |

| (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 |
|---|---|---|---|---|
| 0 650 | Continued From page 19<br><br>a limited number of staff are involved or the situation has occurred only occasionally).<br><br>The findings include:<br><br>ULP-B was hired by the licensee on November 3, 2025.<br><br>ULP-B's personnel record lacked evidence an RN conducted direct supervision of staff performing medication administration (a delegated task) within 30 days of providing services.<br><br>On April 6, 2026, at 11:30 a.m., clinical nurse supervisor (CNS)-A stated they did ensure ULPs were competent in performing any delegated task that CNS-A had trained ULPs to do. CNS-A stated they did not document that they conducted the supervision but believed he had conducted observations of ULP-B completing medication administration tasks to ensure ULP-B was competent.<br><br>During interview on April 6, 2026, at 10:15 a.m., ULP-B stated CNS-A had trained them on medication administation and was aware of CNS-A observing them complete the task of administering medications to residents.<br><br>The licensee's Staff Competency policy dated January 1, 2025, indicated evaluation of competence will be evaluated during on-site supervision of services.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 650 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 42025 | A. BUILDING: _____ B. WING _____ | 04/10/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COLFAX CAREVIEW INC | 8332 COLFAX AVE S BLOOMINGTON, MN 55420 |

| (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 |
|---|---|---|---|---|
| 0 660 | Continued From page 20 | 0 660 | | |
| 0 660 SS=F | 144G.42 Subd. 9 Tuberculosis prevention and control<br><br>(a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines.<br>(b) The facility must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to establish and maintain a tuberculosis (TB) infection control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included completion of a facility TB risk assessment and TB testing results for one of two employees (clinical nurse supervisor (CNS)-A).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 | 0 660 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 42025 | A. BUILDING: _____ B. WING _____ | 04/10/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COLFAX CAREVIEW INC | 8332 COLFAX AVE S BLOOMINGTON, MN 55420 |

| (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 |
|---|---|---|---|---|
| 0 660 | Continued From page 21<br>affect a large portion or all of the residents).<br><br>The findings include:<br><br>TB RISK ASSESSMENT<br>The licensee lacked completion of a Facility TB Risk Assessment.<br><br>CNS-A<br>CNS-A was hired on May 9, 2025.<br><br>CNS-A's undated Baseline TB Screening Tool for Health Care Workers (HCWs), indicated an assessment for current symptoms of active TB disease and TB history was completed; however the form lacked a signature as to whom completed the form.<br><br>CNS-A's employee record included a handwritten Tuberculin Skin Test (TST) Report which indicated on May 7, 2025, CNS-A received a TST. The form also indicated on May 9, 2025, the TST was negative for tuberculosis exposure.<br><br>CNS-A's employee record lacked a second step TST.<br><br>On April 6, 2026, at 11:25 a.m., CNS-A stated they would provide a completed TB risk assessment. CNS-A stated they believed they completed the TB risk assessment but did not know for sure where it was located. CNS-A acknowledged the TB Screening Tool for CNS-A did not have a date as to when the assessment was completed; and the assessment did not indicate who had completed the assessment. CNS-A acknowledged their TST for the second step was not completed but believed it had been. CNS-A stated he would need to locate this information. | 0 660 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 42025 | A. BUILDING: _____ B. WING _____ | 04/10/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COLFAX CAREVIEW INC | 8332 COLFAX AVE S BLOOMINGTON, MN 55420 |

| (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 |
|---|---|---|---|---|
| 0 660 | Continued From page 22<br><br>The licensee's Tuberculosis Screening policy dated January 1, 2025, indicated the licensee would observe the recommended precautions related to TB prevention as identified by the CDC including completing a TB Risk Assessment, TB screening of staff, and staff education.<br><br>Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, indicated on page 10, baseline TB screening consisted of three components: Assessment of current symptoms of active TB disease; assessment of TB history; and testing for the presence of infection with TB by administration of either a two-step TST or single IGRA. Also, page 11 indicated that an employee could begin work with patients after a negative TB symptom screen and a negative first step TST or TB blood test (IGRA) dated within 90 days before hire. The second TST could be performed after HCW started working with patients.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 660 | | |
| 0 680 SS=F | 144G.42 Subd. 10 Disaster planning and emergency preparedness<br><br>(a) The facility must meet the following requirements:<br>(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; | 0 680 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 42025 | A. BUILDING: _____ B. WING _____ | 04/10/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COLFAX CAREVIEW INC | 8332 COLFAX AVE S BLOOMINGTON, MN 55420 |

| (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 |
|---|---|---|---|---|
| 0 680 | Continued From page 23<br><br>(2) post an emergency disaster plan prominently;<br>(3) provide building emergency exit diagrams to all residents;<br>(4) post emergency exit diagrams on each floor; and<br>(5) have a written policy and procedure regarding missing residents.<br>(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.<br>(c) The facility must meet any additional requirements adopted in rule.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to complete a written emergency disaster plan with all required content and failed to post the emergency plan prominently. This had the potential to affect all current residents receiving services under the assisted living license, staff, and visitors to the facility.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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).<br><br>The findings include: | 0 680 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 42025 | A. BUILDING: _____ B. WING _____ | 04/10/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COLFAX CAREVIEW INC | 8332 COLFAX AVE S BLOOMINGTON, MN 55420 |

| (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 |
|---|---|---|---|---|
| 0 680 | Continued From page 24<br><br>On April 6, 2026, at 11:15 a.m., during the facility tour, the surveyor observed the emergency disaster plan was not posted.<br><br>The licensee's undated plan lacked evidence of the following required content:<br>- a comprehensive program to include infectious diseases and pandemics;<br>- a description of the population served by the licensee;<br>- process for emergency preparedness (EP) cooperation with state and local EP officials/organizations;<br>- procedure for tracking staff and residents;<br>- subsistence needs for staff and residents during emergency situation;<br>- development of policies/procedures to address:<br>- evacuation plan (not customized for the facility);<br>- fire (not customized for the facility);<br>- shelter in place;<br>- a tracking system used to document locations or residents and staff;<br>- the medical record documentation system to preserve resident information;<br>- emergency staff strategies;<br>- the facilities role in providing care and treatment at alternative sites;<br>- a communication plan that included:<br>- arrangement with other facilities ;<br>- names and contact information for staff, resident physicians, other facilities;<br>- contact information for federal, state, tribal, local EP staff, ombudsman;<br>- primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management agencies;<br>- a method of sharing information and | 0 680 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 42025 | A. BUILDING: _____ B. WING _____ | 04/10/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COLFAX CAREVIEW INC | 8332 COLFAX AVE S BLOOMINGTON, MN 55420 |

| (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 |
|---|---|---|---|---|
| 0 680 | Continued From page 25<br><br>medical documentation for residents;<br>- a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy;<br>-a method of sharing information from the emergency plan with residents and their families;<br>- EP training and testing program;<br>- EP training program for staff (including documentation of training provided); and<br>- EP testing/annual testing requirements.<br><br>On April 6, 2026, at 2:00 p.m., clinical nurse supervisor (CNS)-A acknowledged the licensee was missing required content in the emergency disaster plan and stated he believed licensed assisted living director (LALD)-C was responsible for developing the emergency preparedness plan.<br><br>Minnesota Administrative Rule 4659.0100 dated August 11, 2021, indicated assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.72, or successor requirements. This part referenced documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types: Interpretive Guidance."<br><br>No additional information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 680 | | |
| 01320 SS=D | 144G.60 Subd. 4 (a) Unlicensed personnel<br><br>(a) Unlicensed personnel providing assisted living | 01320 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 42025 | A. BUILDING: _____ B. WING _____ | 04/10/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COLFAX CAREVIEW INC | 8332 COLFAX AVE S BLOOMINGTON, MN 55420 |

| (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 |
|---|---|---|---|---|
| 01320 | Continued From page 26<br><br>services must have:<br>(1) successfully completed a training and competency evaluation appropriate to the services provided by the facility and the topics listed in section 144G.61, subdivision 2, paragraph (a); or<br>(2) demonstrated competency by satisfactorily completing a written or oral test on the tasks the unlicensed personnel will perform and on the topics listed in section 144G.61, subdivision 2, paragraph (a); and successfully demonstrated competency on topics in section 144G.61, subdivision 2, paragraph (a), clauses (5), (7), and (8), by a practical skills test.<br>Unlicensed personnel who only provide assisted living services listed in section 144G.08, subdivision 9, clauses (1) to (5), shall not perform delegated nursing or therapy tasks.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure training and/or competencies were completed and documented for one of one unlicensed personnel ((ULP)-B).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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).<br><br>The findings include:<br><br>ULP-B was hired on November 3, 2025. | 01320 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 42025 | A. BUILDING: _____ B. WING _____ | 04/10/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COLFAX CAREVIEW INC | 8332 COLFAX AVE S BLOOMINGTON, MN 55420 |

| (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 |
|---|---|---|---|---|
| 01320 | Continued From page 27<br><br>ULP-B's personnel record lacked evidence of training and competency evaluations for the following required topics:<br>- maintenance of a clean and safe environment;<br>- medication, exercise, and treatment reminders;<br>- 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;<br>- awareness of commonly used health technology equipment and assistive devices;<br>- basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; and<br>- range of motioning and positioning.<br><br>During interview on April 6, 2026, at 11:29 a.m., clinical nurse supervisor (CNS)-A confirmed ULP-B was currently working independently and providing assisted living services to residents. CNS-A also confirmed the training and competencies had been missed for ULP-B.<br><br>On April 6, 2026, at 12:50 p.m., CNS-A stated the licensee had staff complete all the required learnings assigned in Educare (common online training). CNS-A stated he reviewed the personnel record before new staff worked independently to ensure the completion of all required training. CNS-A thought he had ensured ULP-B had completed the required training and competencies and was not aware ULP-B had not.<br><br>On April 6, 2026, at 1:30 p.m., ULP-B stated they worked approximately forty hours per week. ULP-B stated their job duties involved taking care of the residents, including assistance with medication, bathing, and dressing. ULP-B stated they believed they had completed their training | 01320 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 42025 | A. BUILDING: _____ B. WING _____ | 04/10/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COLFAX CAREVIEW INC | 8332 COLFAX AVE S BLOOMINGTON, MN 55420 |

| (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 |
|---|---|---|---|---|
| 01320 | Continued From page 28<br><br>and had confirmed they were currently working independently with the residents.<br><br>The licensee's Staff Competency policy dated January 1, 2025, indicated all residents will receive quality service delivered by staff who are educated and competent in the delivery of assisted living services.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01320 | | |
| 01530 SS=D | 144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De-<br><br>(a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements:<br>(1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter;<br>(2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until | 01530 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 42025 | A. BUILDING: _____ B. WING _____ | 04/10/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COLFAX CAREVIEW INC | 8332 COLFAX AVE S BLOOMINGTON, MN 55420 |

| (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 |
|---|---|---|---|---|
| 01530 | Continued From page 29<br><br>this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter;<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review the licensee failed to ensure employees completed initial dementia care training (at least eight hours within 160 working hours of the employment start date) and two hours of initial mental illness training for one of one employee (unlicensed personnel (ULP)-B).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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).<br><br>The findings include: | 01530 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 42025 | A. BUILDING: _____ B. WING _____ | 04/10/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COLFAX CAREVIEW INC | 8332 COLFAX AVE S BLOOMINGTON, MN 55420 |

| (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 |
|---|---|---|---|---|
| 01530 | Continued From page 30<br><br>ULP-B was hired November 3, 2025, to provide direct care services to residents of the licensee.<br><br>ULP-B's record lacked evidence of at least eight hours of initial dementia training within 160 working hours respectively of the employment start date to include:<br>- an explanation of Alzheimer's disease and other dementias;<br>- assistance with activities of daily living;<br>- problem solving with challenging behaviors;<br>- communication skills; and<br>- person-centered planning and service delivery.<br><br>ULP-B's employee Educare (web-based training program) transcript indicated ULP-B had completed 0.5 hours of mental illness training in personality disorders, substance abuse, and de-escalation.<br><br>ULP-B's record lacked evidence that ULP-B had completed the total required initial two hours of training in mental illness and de-escalation topics to include:<br>- recognizing symptoms of common mental illness diagnoses, including but not limited to mood disorders, anxiety disorders, trauma- and stressor-related disorders, personality and psychotic disorders, substance use disorder, and substance misuse;<br>- de-escalation techniques and communication; and<br>- crisis resolution and suicide prevention, including procedures for contacting county crisis response teams and 988 suicide and crisis lifelines.<br><br>During interview on April 6, 2026, at 1:20 p.m., ULP-B stated the education record that the | 01530 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 42025 | A. BUILDING: _____ B. WING _____ | 04/10/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COLFAX CAREVIEW INC | 8332 COLFAX AVE S BLOOMINGTON, MN 55420 |

| (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 |
|---|---|---|---|---|
| 01530 | Continued From page 31<br><br>surveyor was reviewing was correct but ULP-B thought the training that she completed was the required courses needed. ULP-B also stated they worked approximately forty hours per week and their job duties involved taking care of the residents, including assistance with medication, bathing, and dressing.<br><br>During interview on April 6, 2026, clinical nurse supervisor (CNS)-A stated staff were assigned Educare training courses for all employees. CNS-A stated he was unaware ULP-B had not completed all of their required education and would need to address this with ULP-B.<br><br>The licensee's Dementia Education policy dated January 1, 2025, indicated staff would have at least eight hours of initial dementia education within one hundred sixty hours of employment start date.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01530 | | |
| 01620 SS=F | 144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring<br><br>(a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment.<br>(b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever | 01620 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 42025 | A. BUILDING: _____ B. WING _____ | 04/10/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COLFAX CAREVIEW INC | 8332 COLFAX AVE S BLOOMINGTON, MN 55420 |

| (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 |
|---|---|---|---|---|
| 01620 | Continued From page 32<br>is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery.<br>(c) Resident reassessment and monitoring must be conducted by a registered nurse:<br>(1) no more than 14 calendar days after initiation of services;<br>(2) as needed based on changes in the resident's needs; and<br>(3) at least every 90 calendar days.<br>(d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment.<br>(e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review.<br>(f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. | 01620 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 42025 | A. BUILDING: _____ B. WING _____ | 04/10/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COLFAX CAREVIEW INC | 8332 COLFAX AVE S BLOOMINGTON, MN 55420 |

| (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 |
|---|---|---|---|---|
| 01620 | Continued From page 33<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted ongoing resident monitoring and reassessment 14 calendar days from the initial assessment for two of two residents (R1, R2).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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).<br><br>The findings include:<br><br>R1 was admitted on October 4, 2025, with diagnoses that included type II diabetes with other circulatory complications.<br><br>R1's record included a Pre-Admission Assessment (Nursing) dated October 3, 2025.<br><br>R1's record lacked documentation an RN completed reassessment and monitoring no more than 14 calendar days after initiation of services on October 4, 2025.<br><br>R2 was admitted on October 4, 2025, with diagnoses that included chronic obstructive pulmonary disease.<br><br>R2's record included a Pre-Admission Assessment (Nursing) dated October 3, 2025, an initial assessment completed on admission October 4, 2025. | 01620 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 42025 | A. BUILDING: _____ B. WING _____ | 04/10/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COLFAX CAREVIEW INC | 8332 COLFAX AVE S BLOOMINGTON, MN 55420 |

| (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 |
|---|---|---|---|---|
| 01620 | Continued From page 34<br><br>R2's record lacked documentation an RN completed reassessment and monitoring no more than 14 calendar days after initiation of services on October 4, 2025.<br><br>During interview on April 6, 2026, at 2:30 p.m., clinical nurse supervisor (CNS)-A acknowledged R1 and R2's records were missing the required assessments. CNS-A stated when completing assessements he completesdan initial assessment, an assessment within 14 days of completing the initial assessment, a 90 day assessment, and any change of condition would negate an assessment. CNS-A could not explain as to why R1 and R2's records lacked an assessment being completeed within 14 days of the initial assessment. CNS-A stated he must have overlooked or forgotten to complete the assessments but was aware when they need to be completed.<br><br>The licensee's Nursing Assessment and Reassessment of Residents policy was requested but not received.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01620 | | |
| 01640 SS=F | 144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to<br><br>(a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan.<br>(b) The service plan and any revisions must include a signature or other authentication by the | 01640 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 42025 | A. BUILDING: _____ B. WING _____ | 04/10/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COLFAX CAREVIEW INC | 8332 COLFAX AVE S BLOOMINGTON, MN 55420 |

| (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 |
|---|---|---|---|---|
| 01640 | Continued From page 35<br><br>facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities.<br>(c) The facility must implement and provide all services required by the current service plan.<br>(d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable.<br>(e) Staff providing services must be informed of the current written service plan.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to implement all services included in the service plan for one of two residents (R1).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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).<br><br>The findings include:<br><br>R1's assessment dated February 2, 2026, indicated R1 was unsafe to smoke cigarettes without supervision. | 01640 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 42025 | A. BUILDING: _____ B. WING _____ | 04/10/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COLFAX CAREVIEW INC | 8332 COLFAX AVE S BLOOMINGTON, MN 55420 |

| (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 |
|---|---|---|---|---|
| 01640 | Continued From page 36<br><br>R1's Master Care Plan/Addendum to Contract Waiver dated April 4, 2026, indicated R1 was not safe to smoke independently and required staff supervision when smoking.<br><br>During observation on April 6, 2026, at 12:06 p.m., the surveyor observed R1 go out the kitchen door to the back yard area. R1 was observed obtaining a lighter from his pant pocket and a cigarette was in his right hand. R1 was observed lighting the cigarette and proceeded to smoke. During this time unlicensed personnel (ULP)-B was sitting in a chair in a reception area by the front door of the home and was noted to not be observing R1 smoking. There were no other staff present observing R1 smoking at the time.<br><br>During interview on April 6, 2026, at 12:20 p.m., ULP-B stated they did not supervise R1 when he would go outside to smoke. ULP-B stated they were not aware R1 needed to be supervised.<br><br>During interview on April 6, 2026, at 1:24 p.m., clinical nurse supervisor (CNS)-A stated R1 was assessed as not being safe to smoke independently and stated that ULPs were educated on this and were aware they needed to supervise R1 when he was smoking.<br><br>The licensee's Service Plan policy dated January 1, 2025, indicated the licensee would implement and provide all services required by the current service plan.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01640 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 42025 | A. BUILDING: _____ B. WING _____ | 04/10/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COLFAX CAREVIEW INC | 8332 COLFAX AVE S BLOOMINGTON, MN 55420 |

| (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 |
|---|---|---|---|---|
| 01970 SS=D | 144G.72 Subd. 6 Treatment and therapy orders<br><br>There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to obtain a treatment or therapy management prescriber's order for one of one residents (R1).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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).<br><br>The findings include:<br><br>During tour of licensee's establishment with clinical nurse supervisor (CNS)-A and unlicensed personnel (ULP)-B on April 6, 2026, at 10:00 a.m., the surveyor observed a locked file cabinet in a locked closet that contained resident medications and medical supplies. R3's medication drawer consisted of medications and blood glucose monitoring supplies. CNS-A informed the surveyor that R3 was admitted with | 01970 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 42025 | A. BUILDING: _____ B. WING _____ | 04/10/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COLFAX CAREVIEW INC | 8332 COLFAX AVE S BLOOMINGTON, MN 55420 |

| (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 |
|---|---|---|---|---|
| 01970 | Continued From page 38<br><br>a diagnosis of type 2 diabetes and CNS-A had attempted to reach R3's physician to obtain an order to monitor R3's blood glucose levels. CNS-A stated he was having ULPs obtain blood glucose levels by conducting finger stick blood testing daily as CNS-A felt doing this was considered a nursing assessment.<br><br>During the entrance conference on April 6, 2026, at 10:35 a.m., CNS-A stated the licensee was familiar with current minimum assisted living requirements. CNS-A stated resident service plans were updated to include services being provided to residents and a signature was obtained by the resident or resident's representative and offered a copy of the updated service plan.<br><br>R3 was admitted on March 8, 2026, with diagnoses including liver cell carcinoma and type 2 diabetes.<br><br>R3's Service Plan (Waiver)-Addendum to Contract dated March 20, 2026, indicated R3 received the following services: medication management, blood glucose monitoring, bathing, housekeeping, and laundry.<br><br>R3's prescriber orders dated March 16, 2026, did not include orders for daily blood glucose monitoring.<br><br>The licensee's Prescriber's Orders policy dated January 1, 2025, indicated written orders from an authorized prescriber would be obtained for all medications and treatments with which the assisted living facility assists residents.<br><br>No further information was provided. | 01970 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 42025 | A. BUILDING: _____ B. WING _____ | 04/10/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COLFAX CAREVIEW INC | 8332 COLFAX AVE S BLOOMINGTON, MN 55420 |

| (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 |
|---|---|---|---|---|
| 01970 | Continued From page 39<br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01970 | | |

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

# Food & Beverage Inspection Report



## Establishment Info

Colfax Careview Inc
8332 Colfax Ave S
Bloomington, MN 55420
Hennepin County
Parcel:

Phone:

## License Info

License: HFID 42025

Risk:
License:
Expires on:
CFPM: Muse Mohamud Mohamed
CFPM #: 57864; Exp: 4/23/2028

## Inspection Info

Report Number: F1063261089
Inspection Type: Full - Single
Date: 4/7/2026 Time: 11:00 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 3
Total Priority 2 Orders: 3
Total Priority 3 Orders: 0
Delivery:

**! New Order: 2-200 Employee Health**
2-201.11C *Priority Level: Priority 1 CFP#: 3*
*MN Rule 4626.0040C* The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.
COMMENT: NO EMPLOYEE ILLNESS LOG WAS AVAILABLE DURING THE INSPECTION. ILLNESS POLICY WAS DISCUSSED WITH OPERATOR AND A COPY OF THE MDH EMPLOYEE ILLNESS LOG WAS SENT WITH THE REPORT.
*Comply By: 4/7/2026 Originally Issued On: 4/7/2026*

**! New Order: 3-300B Protection from Contamination: cross-contamination, eggs**
3-302.11A(1) *Priority Level: Priority 1 CFP#: 15*
*MN Rule 4626.0235A(1)* Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.
COMMENT: RAW SHELL EGGS IN REFRIGERATOR WERE STORED ON TOP SHELF OVER READY TO EAT FOOD ITEMS (EX. LETTUCES, MILK, YOGURT). DISCUSSED FOOD STORAGE WITH OPERATOR AND EGGS WERE MOVED BELOW AND AWAY FROM READY TO EAT FOODS.
*Comply By: Complied On Site Originally Issued On: 4/7/2026*

**! New Order: 3-500B Microbial Control: hot and cold holding**
3-501.16A2 *Priority Level: Priority 1 CFP#: 22*
*MN Rule 4626.0395A2* Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.
COMMENT: TCS ITEMS IN FRIDGE MEASURED OVER 41 DEGREES F. DISCUSSED TEMPERATURE REQUIREMENTS WITH OPERATOR. REFRIGERATOR TEMPERATURE WAS TURNED DOWN. COMPLY WITH RULE ABOVE.
*Comply By: 4/7/2026 Originally Issued On: 4/7/2026*

**New Order: 4-300 Equipment Numbers and Capacities**
4-302.12A *Priority Level: Priority 2 CFP#: 36*
*MN Rule 4626.0705A* Provide a readily accessible food temperature measuring device to ensure attainment and maintenance of food temperatures.
COMMENT: NO FOOD THERMOMETER WAS AVAILABLE DURING THE INSPECTION. DISCUSSED USING FOOD THERMOMETER TO MEASURE COOK TEMPERATURES AND MONITOR FOOD TEMPERATURES IN THE FRIDGE. COMPLY WITH RULE ABOVE.
*Comply By: 4/10/2026 Originally Issued On: 4/7/2026*

**New Order: 4-300 Equipment Numbers and Capacities**
4-302.13B *Priority Level: Priority 2 CFP#: 48*
*MN Rule 4626.0710B* Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.
COMMENT: NO DISH MACHINE TEST WAS AVAILABLE DURING THE INSPECTION. OBTAIN IRREVERSIBLE REGISTERING TEST STRIPS OR THERMOMETER TO TEST DISH MACHINE SANITIZING TEMPERATURE.
*Comply By: 4/14/2026 Originally Issued On: 4/7/2026*

**New Order: 4-300 Equipment Numbers and Capacities**
4-302.14 *Priority Level: Priority 2 CFP#: 48*
*MN Rule 4626.0715* Provide an appropriate test kit to accurately measure sanitizing solutions.
COMMENT: CHLORINE IS USED TO SANITIZE LARGE WOODEN CUTTING BOARD BUT NO CHLORINE TEST STRIPS WERE AVAILABLE. PROVIDE TEST STRIPS TO ENSURE CHLORINE SOLUTION MEASURES BETWEEN 50-200 PPM.
*Comply By: 4/14/2026 Originally Issued On: 4/7/2026*

## Food & Beverage General Comment

Inspection was completed with MDH Elyse Jones as the lead Health Regulation Division Nurse Evaluator completing the site survey. Nurse evaluator was not on site during kitchen inspection, all findings were reviewed over email.

The facility has a residential kitchen. Food must be prepared for same day service only. The kitchen has vinyl panel flooring, smooth painted walls with tile backsplash, smooth ceiling, smooth countertops, and wooden cabinetry. All found to be in good condition.

Equipment includes a two-basin sink with one compartment designated for handwashing, and ANSI residential fridge/freezer & dish machine.

Discussed highly susceptible populations, glove use, same day food service, food storage & temperature control, cross contamination prevention, cleaning procedures, sanitizers, test kits, ware washing, pest control, vomit cleanup procedures, and employee illness policy.

Contact Health Regulation Division for plan review approval when facility/kitchen undergoes remodeling, major equipment additions, or changes of equipment due to a menu change.

***If any customer complains of illness, establishment is required to notify the Minnesota Department of Health and provide the foodborne illness hotline phone number to the customer: 1-877-366-3455***

**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 Metro District Office inspection report number F1063261089 from 4/7/2026**

Sam-Sam Ali
Operator

Laura Yang,
Public Health Sanitarian 1
651-201-3581
laura.yang@state.mn.us

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

# Temperature Observations/Recordings



## Establishment Info

Colfax Careview Inc
Bloomington
County/Group: Hennepin County

## Inspection Info

Report Number: F1063261089
Inspection Type: Full
Date: 4/7/2026
Time: 11:00 AM

**Food Temperature: Product/Item/Unit:** Tomato Sauce**; Temperature Process:** Cold-Holding
**Location:** Refrigerator at 45 Degrees F.
Comment:
*Violation Issued?: Yes*

**Food Temperature: Product/Item/Unit:** Milk**; Temperature Process:** Cold-Holding
**Location:** Refrigerator at 45 Degrees F.
Comment:
*Violation Issued?: Yes*

**Food Temperature: Product/Item/Unit:** Hot Dog**; Temperature Process:** Thawing
**Location:** Refrigerator at 29 Degrees F.
Comment:
*Violation Issued?: No*

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

# Sanitizer Observations/Recordings



## Establishment Info

Colfax Careview Inc
Bloomington
County/Group: Hennepin County

## Inspection Info

Report Number: F1063261089
Inspection Type: Full
Date: 4/7/2026
Time: 11:00 AM

**Sanitizing Equipment:** **Product:** Hot Water**; Sanitizing Process:** Dish Machine
**Location:** Kitchen **Equal To** 160 Degrees F.
Comment:
*Violation Issued?: No*