



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

June 2, 2026

Licensee
Cornerstone Residence Fosston
115 1st Street East
Fosston, MN 56542

RE: Project Number(s) SL30360016

Dear Licensee:

On May 8, 2026, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on February 19, 2026. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the February 19, 2026 survey.

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

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on February 19, 2026, found not corrected at the time of the May 8, 2026, follow-up survey and/or subject to penalty assessment are as follows:

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

The details of the violations noted at the time of this follow-up survey completed on May 8, 2026 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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

DOCUMENTATION OF ACTION TO COMPLY

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;

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

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

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

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

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

To submit a hearing request, please visit:

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

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

We urge you to review these orders carefully. If you have questions, please contact Jessie Chenze at 218-332-5175.

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

Sincerely,



Jessie Chenze, Supervisor
State Evaluation Team
Email: Jessie.Chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

KKM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 05/08/2026
NAME OF PROVIDER OR SUPPLIER CORNERSTONE RESIDENCE FOSSTON			STREET ADDRESS, CITY, STATE, ZIP CODE 115 1ST STREET EAST FOSSTON, MN 56542		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL30360016-1 On May 7, 2026, through May 8, 2026, the Minnesota Department of Health conducted a follow-up survey for the above provider to follow-up on orders issued pursuant to a survey completed on February 19, 2026. At the time of the survey, there were 28 residents; 28 receiving services under the Assisted Living Facility with Dementia Care license. As a result of the follow-up survey, the following orders were issued and/or reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	{0 480}			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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

Minnesota Department of Health

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{0 480}	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by:	{0 480}	Not reviewed during this survey.		
{0 775} SS=D	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a	{0 775}			

Minnesota Department of Health

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{0 775}	Continued From page 3 limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated May 7, 2026, for the specific violations related the physical environment under Minnesota Statute 144G.	{0 775}			
{0 780} SS=D	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;	{0 780}			

Minnesota Department of Health

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{0 780}	Continued From page 4	{0 780}			
{0 810} SS=F	This MN Requirement is not met as evidenced by: 144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill	{0 810}	Not reviewed during this survey.		

Minnesota Department of Health

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{0 810}	Continued From page 5 every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by:	{0 810}	Not reviewed during this survey.		
{01760} SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by:	{01760}			
{01950} SS=E	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to	{01950}			

Minnesota Department of Health

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{01950}	Continued From page 6 perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by:	{01950}	Not reviewed during this survey.		
{02320} SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by:	{02320}			

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL30360016-1	Date: May 7, 2026
Facility Name: Cornerstone Residence of Fosston	
Facility Address: 115 1 st Street East, Fosston, MN 56542	

☒ TAG IDENTIFICATION: 0775

SCOPE/ SEVERITY: Level 2; Isolated

1.

Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]
2.

Controlled egress locking systems shall have the capability of being unlocked from the fire command center, a nursing station, or other approved location. [Minn. Stat. 144G.45 subd. 2; MSFC 1010.1.9.7]

Comments: The licensee provided a plan of correction for the controlled egress locking system. Record review of the available documentation indicated the licensee was working with an architect to complete the necessary drawings and paperwork for plan submission to Minnesota Department of Health Engineering Services for review and approval.

Record review of the available documentation indicated the controlled egress locking system was still not compliant on the day of the follow up. The licensee provided documentation indicating they were working on corrective actions from the initial issue of the order on February 17, 2026, to the current date of the follow-up survey.



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

March 18, 2026

Licensee

Cornerstone Residence Fosston

115 1st Street East

Fosston, MN 56542

RE: Project Number(s) SL30360016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 19, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;

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

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

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

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

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

pursuant to this survey:

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$1,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

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

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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

Cornerstone Residence Fosston

March 18, 2026

Page 3

a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in cursive script that reads "Jessie Chenze".

Jessie Chenze, Supervisor

State Evaluation Team

Email: Jessie.Chenze@state.mn.us

Telephone: 218-332-5175 Fax: 1-866-890-9290

CLN

Minnesota Department of Health

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0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30360016-0 On February 17, 2026, through February 19, 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 27 residents; 27 receiving services under the Assisted Living Facility with Dementia Care license. An immediate correction order was identified on February 18, 2026, issued for SL30360016-0, tag identification 1290. The licensee took action on February 18, 2026, to mitigate the risk; however, the scope and level remains at level 3/Widespread (I).	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480			

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NAME OF PROVIDER OR SUPPLIER CORNERSTONE RESIDENCE FOSSTON		STREET ADDRESS, CITY, STATE, ZIP CODE 115 1ST STREET EAST FOSSTON, MN 56542			
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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated February 19, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480			

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0 480	Continued From page 3	0 480			
	TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.				
0 775 SS=E	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated February 17, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775			

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0 780 SS=D	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a	0 780			

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0 780	Continued From page 5 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated February 17, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans	0 810			

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0 810	Continued From page 6 upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated	0 810			

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0 810	Continued From page 7 February 17, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure current employee records contained all the required content to include a current background study clearance letter for one of eight employees (unlicensed personnel (ULP)-I). This had the potential to affect all residents living within the facility. This practice resulted in a level three violation (a	01290			

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01290	Continued From page 8 violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: This resulted in an immediate correction order on February 18, 2026. During the entrance conference on February 17, 2026, at 10:47 a.m., licensed assisted living director (LALD)-A stated the licensee was aware of required contents in an employee record. ULP-I was hired on September 19, 2023, to provide direct care services to residents at the facility. On February 18, 2026, at 5:39 a.m., the surveyor called the licensee and spoke to ULP-I. ULP-I stated ULP-I was the only ULP working the overnight shift in the secured (requires a keypad to enter and exit) dementia care unit and one other ULP was present in the building working on the assisted living unit. On February 18, 2026, at 8:43 a.m. the surveyor observed ULP-I assist R4 with toileting. ULP-I was unsupervised and worked independently. The licensee's Schedule dated February 7, 2026, through February 20, 2026, indicated ULP-I was scheduled to work 11 shifts including evenings and overnights. The licensee's NETStudy 2.0 Roster printed	01290			

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01290	Continued From page 9 February 17, 2026, indicated ULP-I's background study was submitted on February 17, 2026 (date of survey initiation). The background study indicated determination was in process and supervision was required. ULP-I's employee record lacked a current cleared background study and ULP-I was not provided with direct supervision until the background study had cleared. On February 18, 2026, at 9:21 a.m., chief financial officer (CFO)-H stated the LALD for the licensee was responsible for submitting background checks on NETStudy 2.0 upon hire of employment, however, CFO-H was the current sensitive information person (SIP), on the NETStudy 2.0 website, for the licensee at this time due to staff turnover with the LALD position. CFO-H stated the licensee completed a NETStudy background check on ULP-I yesterday (February 17, 2026), after the licensee reviewed the NETStudy roster and ULP-I was not listed. CFO-H further stated ULP-I had a previous background study application, however, ULP-I was listed as separated from the licensee. CFO-H stated it was an oversight regarding ULP-I's supervision after ULP-I's background study was submitted. Regional licensed assisted living director (RLALD)-G further stated another ULP was present in the building when ULP-I worked the overnight shift, however, ULP-I was not directly supervised. The licensee's 4.02 Background Studies policy dated August 12, 2024, indicated using the MN (Minnesota) DHS (Department of Human Services) NetStudy online program, (licensee name) will initiate a background study on all employees being considered for hire. The policy	01290			

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01290	Continued From page 10 further indicated new hires shall not be permitted to interact or provide services to tenants or clients (residents) of (licensee name) except under the direct supervision (eyesight) of another qualified staff person. Continuous Direct Supervision defined in NETStudy 2.0 System User Manual Updated July 7, 2023, page 7: Continuous, Direct Supervision - An individual is within sight or hearing of the program's supervising individual to the extent that the program's supervising individual is capable at all times of intervening to protect the health and safety of the persons served by the program. Direct Contact Services - Providing face-to-face care, training, supervision, counseling, consultation, or medication assistance to persons served by the entity. Supervision defined in, NETStudy 2.0 System User Manual Updated July 7, 2023, page 53: Supervision Status Study subjects must be under continuous, direct supervision until the study subject is determined eligible or until the entity is notified by DHS that the study subject may provide unsupervised services while the background study is being completed. The supervision status is shown in the "Supervision Required" column for convenience. However, programs are instructed to rely on background study notices for supervision status and other background study determination information. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290			
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication	01760			

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01760	Continued From page 11 Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered per prescriber orders for one of eight residents (R2) observed during medication administration. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on February 17, 2026, at 10:33 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management to residents at the facility.	01760			

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01760	Continued From page 12 R2's diagnoses included hypertension (HTN-high blood pressure), chronic kidney disease, and weakness. R2's Service Plan dated January 27, 2026, indicated R2's services included medication administration five times per day. R2's prescriber orders dated January 23, 2026, included an order for diclofenac gel (Voltaren- for pain) 1% apply 4 (four) grams (g) topically to thigh and hip four times per day. R2's Medication Sheet dated February 2026, indicated diclofenac sodium 1% gel apply 4 g to thighs and hips four times per day. Left side for sure ask about pain on right [sic]. On February 17, 2026, at 12:51 p.m., the surveyor observed unlicensed personnel (ULP)-F apply approximately a pea size amount of diclofenac sodium 1% gel to R2's left thigh. The surveyor did not observe ULP-F apply diclofenac gel 1% to R2's left hip or use a dosing card to verify 4 g of diclofenac sodium 1% gel. On February 17, 2026, at 1:35 p.m., ULP-F stated ULP-F was never trained to use a dosing card for the administration of diclofenac sodium 1% gel. The surveyor and ULP-F reviewed R2's diclofenac sodium 1% gel prescription box and ULP-F removed the dosing card from inside the box. On February 18, 2026, at 2:04 p.m., CNS-B stated ULPs were trained to use the dosing card from the prescription box of diclofenac sodium 1% gel to ensure the correct dosage was being administered to R2.	01760			

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01760	Continued From page 13 The manufacturer's instructions for Voltaren dated July 2009, indicated the proper amount of Voltaren Gel should be measured using the dosing card supplied in the drug product carton. In addition, the dosing card should be used for each application of drug product. The licensee's 7.24 Medication Error policy dated September 3, 2025, indicated the person responsible for the error or the person who discovered the medication error will contact the LPN (licensed practical nurse) or RN (registered nurse) and explain the situation in detail with the medication name, dosage, and amount given, the time medication was administered, as well as the client (resident) involved [sic]. The licensee's 7.15 Medication and Treatment-Administration and Delegation policy dated April 5, 2023, indicated the ULP must demonstrate their ability to competently follow the delegated medication administration to the RN including the complete procedure of checking a resident's medication administration record (MAR), the preparation of medication administration, and the administration of the medication to the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01950 SS=E	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to	01950			

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01950	Continued From page 14 perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) specified, in writing, specific instructions for two of three residents (R3, R6) receiving treatment management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on February 17,	01950			

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NAME OF PROVIDER OR SUPPLIER CORNERSTONE RESIDENCE FOSSTON		STREET ADDRESS, CITY, STATE, ZIP CODE 115 1ST STREET EAST FOSSTON, MN 56542			
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01950	Continued From page 15 2026, at 10:43 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided treatment services to residents. R3 R3's diagnoses included lymphedema (swelling in the body tissues) and cognitive impairment. R3's Service Plan dated November 1, 2025, indicated R3's services included TEDs (compression stockings to reduce swelling in the legs) assistance twice daily and delegated nursing procedure (compression sleeve/lymphedema wraps- used to reduce swelling in the legs) twice daily. R3's prescriber orders dated October 24, 2025, included orders for the following: -compression sleeve/wrap (lymphedema wraps) apply at night and off in the morning; and -TEDS apply on in the morning and off at night. R3's Medication Sheet dated January 2026, and February 2026, respectively, indicated R3's lymphedema wraps were put on every night and removed every morning. In addition, R3's TEDS were put on every morning and removed every night. On February 17, 2026, at 12:54 p.m., the surveyor observed unlicensed personnel (ULP)-F assist R3 with toileting. During the observation, the surveyor observed R3 wearing TEDS. R3 stated R3 wore TEDS during the day, and lymphedema wraps at night to reduce the swelling in R3's legs. R3's record lacked specific instructions for ULPs of when to notify the RN regarding TEDS and lymphedema wraps when a problem arises.	01950			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/19/2026
NAME OF PROVIDER OR SUPPLIER CORNERSTONE RESIDENCE FOSSTON			STREET ADDRESS, CITY, STATE, ZIP CODE 115 1ST STREET EAST FOSSTON, MN 56542		
(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
01950	Continued From page 16 R6 R6's diagnoses included asthma (difficult breathing), lumbar disc degeneration (pain, weakness, or numbness in the lower back), and schizoaffective disorder. R6's Service Plan dated October 22, 2025, indicated R6's services included assisting R3 to apply and remove TENS (transcutaneous electrical nerve stimulation- to treat acute or chronic pain) unit three times per day. R6's prescriber orders dated February 21, 2025, included an order for TENS unit for 30 minutes per day up to three times daily as needed. R6's Medication Sheet dated January 2026, and February 2026, respectively, indicated for ULPs to assist R6 with putting on and removing R6's TENS unit up to three times per day as needed. R6's record lacked specific instructions for ULPs of when to notify the RN regarding TENS when a problem arises. On February 19, 2026, at 11:00 a.m., CNS-B stated R3 and R6's records lacked specific written instructions on when to notify the RN when problems arose with a treatment, however, CNS-B stated ULPs were trained during orientation of when to notify an RN for each specific treatment. CNS-B further stated CNS-B was aware specific written instructions on when to notify the RN were required to be written as part of the resident's treatment plan. The licensee's 7.15 Medication and Treatment-Administration and Delegation policy dated April 5, 2023, indicated a RN must specify, in writing,	01950			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/19/2026
NAME OF PROVIDER OR SUPPLIER CORNERSTONE RESIDENCE FOSSTON		STREET ADDRESS, CITY, STATE, ZIP CODE 115 1ST STREET EAST FOSSTON, MN 56542			
(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
01950	Continued From page 17 specific instructions for each resident and document those instructions in the residents' [sic] record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950			
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the steps of the medication administration process was followed for one of three employees (unlicensed personnel (ULP)-E) observed administering medications. 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).	02320			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/19/2026
NAME OF PROVIDER OR SUPPLIER CORNERSTONE RESIDENCE FOSSTON			STREET ADDRESS, CITY, STATE, ZIP CODE 115 1ST STREET EAST FOSSTON, MN 56542		
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02320	Continued From page 18 The findings include: During the entrance conference on February 17, 2026, at 10:33 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management to residents at the facility. R6's diagnoses included asthma (difficult breathing), lumbar disc degeneration (pain, weakness, or numbness in the lower back), and schizoaffective disorder. R6's Service Plan dated October 22, 2025, indicated R6's services included medication administration five times per day. R6's prescriber orders dated February 21, 2025, included an order for Breo Ellipta (for asthma) 100-25 micrograms (mcg)/actuation (ACT) inhale one puff in the morning to improve breathing. R6's Medication Sheet dated January 2026, and February 2026, respectively, indicated R6 was administered Breo Ellipta 100-25 mcg/ACT one puff in the morning to improve breathing. Instruct/provide resident with a water cup and a spit cup. Instruct resident to rinse mouth out with water and spit water out to prevent thrush. On February 18, 2026, at 8:59 a.m., the surveyor observed ULP-E provide scheduled morning medication administration for R6. ULP-E compared R6's Breo Ellipta inhaler to R6's electronic medication administration record (EMAR), which included instructions to rinse and spit after inhalation of the Breo Ellipta inhaler. ULP-E handed R6 the Breo Ellipta inhaler, R6 inhaled one puff from the Breo Ellipta inhaler, and R6 handed the Breo Ellipta inhaler back to ULP-E. ULP-E proceeded to administer R6's oral	02320			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/19/2026
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02320	Continued From page 19 medications. The surveyor did not observe ULP-E offer R6 water to rinse and spit after inhalation of the Breo Ellipta inhaler. On February 18, 2026, at 1:51 p.m., ULP-E stated ULP-E did not offer R6 water to rinse out R6's mouth and spit after R6 was administered the Breo Ellipta inhaler. ULP-E further stated R6 did not drink water, however, ULP-E should have offered R6 the option to rinse and spit. On February 18, 2026, at 2:12 p.m., CNS-B stated ULPs were trained to offer residents to rinse and spit out the water after certain inhaler administrations. CNS-B further stated ULPs were trained to follow the written instructions on the resident's EMAR. The manufacturer's instructions for Breo Ellipta dated July 202, indicated to rinse mouth with water after you have used the Breo Ellipta inhaler and spit the water out. Do not swallow the water. The licensee's 7.35 Inhaled Medications policy dated July 1, 2022, indicated after the resident has used the inhaler provide the resident the opportunity to rinse out mouth with water and spit out the water once they have rinsed. The licensee's 7.15 Medication and Treatment-Administration and Delegation policy dated April 5, 2023, indicated an RN (registered nurse) must specify, in writing, specific instructions for each resident and document those instructions in the residents' [sic] record. In addition, the ULP must demonstrate their ability to competently follow the delegated medication administration to a RN. No further information was provided.	02320			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/19/2026
NAME OF PROVIDER OR SUPPLIER CORNERSTONE RESIDENCE FOSSTON		STREET ADDRESS, CITY, STATE, ZIP CODE 115 1ST STREET EAST FOSSTON, MN 56542			
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02320	Continued From page 20 TIME PERIOD FOR CORRECTION: Seven (7) days	02320			



Fergus Falls District Office
Minnesota Department of Health
2314 College Way
Fergus Falls , MN 56537
Phone: 651-201-4500

Food & Beverage Inspection Report

Page: 1

Establishment Info

Cornerstone Residence of Fosston
115 1st Street East
Fosston, MN 56542
Polk County
Parcel:

Phone:

License Info

License: HFID 30360

Risk:
License:
Expires on:
CFPM: Tina Olson
CFPM #: 24291; Exp: 10/31/2026

Inspection Info

Report Number: F1049261036
Inspection Type: Full - Single
Date: 2/19/2026 Time: 11:15 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 1
Total Priority 3 Orders: 1
Delivery: Emailed

New Order: 4-500 Equipment Maintenance and Operation

4-502.13 *Priority Level: Priority 3 CFP#: 45*

MN Rule 4626.0830 Discontinue re-use of any single-service and single-use articles.

COMMENT: THE ESTABLISHMENT IS RE-USING COTTAGE CHEESE CONTAINERS TO STORE FOOD IN. PIC INSTRUCTED TO NOT RE-USE SINGLE-USE CONTAINERS TO STORE FOOD. PIC INSTRUCTED TO USE FOOD GRADE STORAGE CONTAINERS TO STORE FOOD.

Comply By: 2/19/2026 Originally Issued On: 2/19/2026

New Order: 5-200C Plumbing: Maintenance, fixture location

5-205.11AB *Priority Level: Priority 2 CFP#: 10*

MN Rule 4626.1110AB The handwashing sink must be accessible at all times for employee use, and must be used only for handwashing.

COMMENT: WHEN INSPECTOR ARRIVED, THERE WERE TWO POT HOLDERS IN THE HAND SINK AND A GARBAGE CAN IN FRONT OF THE HAND SINK. PIC REMOVED THE POT HOLDERS AND MOVED THE GARBAGE CAN. PIC INSTRUCTED TO KEEP THE HAND SINK FREE AND CLEAR AT ALL TIMES.

Comply By: Complied On Site Originally Issued On: 2/19/2026

Food & Beverage General Comment

INSPECTOR MET WITH MDH NURSE EVALUATOR AND ESTABLISHMENT REPRESENTATIVE.

ESTABLISHMENT HAS ONE ANSI CERTIFIED KITCHEN THAT PREPARES AND COOKS FOOD FOR MEMORY CARE RESIDENTS AND FOR THE SERVING KITCHEN.

THE SERVING KITCHEN HAS WOOD CABINETS, PAINTED WALLS, VINYL FLOORING AND LAMINATE COUNTERTOPS.

THE DISH MACHINE TESTED AT 50 PPM CHLORINE, INDICATING THAT DISHES AND UTENSILS ARE BEING PROPERLY SANITIZED.

Things to Remember:

1. The Certified Food Manager should be routinely conducting self inspections to ensure that employees are following proper food handling practices.
2. Educate employees on the importance of reporting to management any illness they have or have had recently. Management should exclude any workers ill with vomiting or diarrhea from handling food, and they should keep an up to

date employee illness log.

3. There should be a Person in Charge at the establishment during all hours of operation. This person should ensure that employees are practicing good hand washing procedures, including being knowledgeable about when hand washing should be done and how to properly wash hands.

4. Employees should use spatula, tongs, deli tissue, gloves, or some other approved means to prevent any direct bare hand contact with ready to eat foods.

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

I acknowledge receipt of the Fergus Falls District Office inspection report number F1049261036 from 2/19/2026

Stephanie Reynolds

Establishment Representative

Stephanie Reynolds,
Public Health Sanitarian 2
218-332-5179
stephanie.reynolds@state.mn.us



Fergus Falls District Office
Minnesota Department of Health
2314 College Way
Fergus Falls , MN 56537

Temperature Observations/Recordings

Page: 1

Establishment Info

Cornerstone Residence of Fosston
Fosston
County/Group: Polk County

Inspection Info

Report Number: F1049261036
Inspection Type: Full
Date: 2/19/2026
Time: 11:15 AM

Food Temperature: **Product/Item/Unit:** Hot Beef; **Temperature Process:** Cooking

Location: Serving Line at 185.5 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** Mashed Potatoes; **Temperature Process:** Cooking

Location: Serving Line at 169 Degrees F.

Comment:

Violation Issued?: No

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

Location: Serving Line at 175 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** Shredded Lettuce; **Temperature Process:** Cold-Holding

Location: Upright Cooler at 39 Degrees F.

Comment:

Violation Issued?: No

New Record: **Product/Item/Unit:** Milk; **Temperature Process:** Cold-Holding

Location: Upright Cooler at Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** Ham; **Temperature Process:** Cold-Holding

Location: Upright Cooler at 39 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** Gravy; **Temperature Process:** Hot-Holding

Location: Steam Table at 156 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** Carrots; **Temperature Process:** Hot-Holding

Location: Steam Table at 164 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** Half and Half; **Temperature Process:** Cold-Holding

Location: Refrigerator at 40 Degrees F.

Comment:

Violation Issued?: No



Fergus Falls District Office
Minnesota Department of Health
2314 College Way
Fergus Falls , MN 56537

Sanitizer Observations/Recordings

Page: 1

Establishment Info

Cornerstone Residence of Fosston
Fosston
County/Group: Polk County

Inspection Info

Report Number: F1049261036
Inspection Type: Full
Date: 2/19/2026
Time: 11:15 AM

Sanitizing Chemical: Product: Chlorine; **Sanitizing Process:** Dish Machine

Location: Dishwashing Area **Equal To** 50 PPM

Comment:

Violation Issued?: No

Sanitizing Chemical: Product: Quaternary Ammonia; **Sanitizing Process:** Wiping Cloth Bucket

Location: 3-Comp Sink **Equal To** 200 PPM

Comment:

Violation Issued?: No

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL30360016-0	Date: February 17, 2026
Facility Name: Cornerstone Residence of Fosston	
Facility Address: 115 1 st Street East, Fosston, MN 56542	

☒ TAG IDENTIFICATION: 0775

SCOPE/ SEVERITY: Level 2; Pattern

TIME PERIOD OF CORRECTION: Seven (7) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]

2. Fire doors shall be maintained to be self-closing and latch as designed. Fire doors shall not be blocked, obstructed, or otherwise made inoperable. [Minn. Stat. 144G.45 subd. 2; MSFC 705]

Comments: The door closers were disconnected from labeled fire doors for resident rooms 115/116, 129, 206, and 213. Director of maintenance (DM)-D stated self-closing hinges for these doors had been ordered as the door closers were too difficult for these residents to operate. Fire doors shall be maintained as designed to contain fire and smoke in the event of an emergency.

3. Controlled egress locking systems shall have the capability of being unlocked from the fire command center, a nursing station, or other approved location. The procedures for operation of the unlocking system shall be described as part of the fire safety and evacuation plan. [Minn. Stat. 144G.45 subd. 2; MSFC 1010.1.9.7]

Comments: During the building tour, the surveyor asked director of maintenance (DM)-D if a remote button or switch was installed that would disengage the controlled egress locking system for the building. DM-D stated there was no button or switch, and he was not aware of this requirement.

4. The means of egress shall be maintained free of obstructions or impediments to full instant use in case of fire or other emergency. [Minn. Stat. 144G.45 subd. 2; MSFC 1031.2]

Comments: There were two emergency exit doors at the main entrance for the assisted living building. One of these doors was locked. This exit door must remain unlocked from the egress side to allow safe passage to the outside in the event of an emergency.

5. Extension cords and flexible cords shall not be a substitute for permanent wiring. [Minn. Stat. 144G.45 subd. 2; MSFC 604.5]

Comments: An extension cord was used to supply power to personal electronics in resident room 317. Improper use of extension cords creates a fire hazard.

6. Building fire alarm systems shall be inspected and tested annually. [Minn. Stat. 144G.45 subd. 2; MSFC 901.6.1]

Comments: The surveyor requested inspection records for the fire alarm system. Director of maintenance (DM)-D stated these reports were not available as the fire alarm system had not been inspected in the last year.

☒ **TAG IDENTIFICATION: 0780**

SCOPE/ SEVERITY: Level 2; Isolated

TIME PERIOD OF CORRECTION: Seven (7) days

1. Smoke alarms interconnected so that actuation of one alarm causes all alarms in the individual dwelling or sleeping unit to operate where more than one smoke alarm is required within an individual dwelling or sleeping unit. [Minn. Stat. 144G.45 subd.2]

Comments: The interior door between resident rooms 115/116 was removed to create one dwelling unit. When director of maintenance (DM)-D tested the smoke alarms, these smoke alarms were not interconnected.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Twenty One (21) days

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

Comments: The surveyor requested records for employee fire safety and evacuation plan (FSEP) training completed in the past twelve months from the licensee. Documentation was not provided. The licensee failed to show they conducted site specific FSEP training with employees at least twice per year.

2. Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. [Minn. Stat. 144G.45 subd.2]

Comments: The surveyor requested records for resident fire safety and evacuation training completed in the past twelve months from the licensee. Documentation was provided for a training session completed on February 21, 2024. Resident training had not been conducted in the last year.

3. Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. [Minn. Stat. 144G.45 subd.2]

Comments: The surveyor requested records for evacuation drills completed between February 2025 and February 2026 from the licensee. Record review of fire drill logs indicated drills were conducted in 2025 during January, April, May, July, and September. In 2026, a fire drill was conducted in January. In the past year, there were three third shift drills, two first shift drills, and one second shift drill. Evacuation drills were not completed at a frequency of every other month, and second shift drills were not conducted twice per year.