DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

May 26, 2026

Licensee
Nouis Home Care Incorporated
308 1st Street Southeast
Little Falls, MN 56345

RE: Project Number(s) SL28501016

Dear Licensee:

On May 14, 2026, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on February 25, 2026. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Jessie Chenze

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

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Electronically Delivered

March 19, 2026

Licensee
Nouis Home Care Incorporated
308 1st Street Southeast
Little Falls, MN 56345

RE: Project Number(s) SL28501016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 25, 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 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00
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 $2,000.00**. 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.

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

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

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

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

If you have any questions, please contact me.

Sincerely,

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

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28501	A. BUILDING: _____ B. WING _____	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOUIS HOME CARE INCORPORATED	308 1ST STREET SE LITTLE FALLS, MN 56345

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL28501016-0 On February 23, 2026, through February 25, 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 36 residents; all 36 receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request	0 460		

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0 460	Continued From page 1 assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (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; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a means for two of two residents (R1, R2) to request assistance for health and safety needs 24 hours a day, seven days a week. This had the potential to affect all residents at the facility. 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:	0 460		

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0 460	Continued From page 2 The licensee held an assisted living facility license effective August 1, 2025, for a capacity of 50 residents, and had a current census of 36 residents. During the entrance conference on February 23, 2026, at 10:00 a.m., licensed assisted living director (LALD)-B stated the licensee was familiar with the current minimum assisted living requirements. LALD-B stated the licensee had no call system in place and if there ever was the need, they would use a web-based call system. LALD-B stated all residents were ambulatory and self-sufficient and the need was not there for a call system. Clinical nurse supervisor (CNS)-A stated no residents were confined to their rooms that would need assistance to get out. R1 R1's diagnoses included hypertension (high blood pressure) and cerebral palsy (neurological disorders affecting movement, muscle tone, and posture). R1's Service Plan dated April 29, 2025, indicated R1 received services including assistance with housekeeping, medication administration, and laundry. R2 R2's diagnoses included schizophrenia (a severe brain disorder characterized by a distortion of reality including hallucination, delusion, and disorganized thinking) and type 2 diabetes (a chronic condition where the body resists insulin or fails to produce enough insulin, resulting in high blood sugar). R2's Service Plan dated April 29, 2025, indicated	0 460		

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0 460	Continued From page 3 R2's services included behavior management, housekeeping, laundry, and medication administration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 460		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions;	0 470		

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0 470	Continued From page 4 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the clinical nurse supervisor (CNS) developed and implemented a staffing plan to determine staffing levels to meet the needs of all residents, which included reviewing the staffing plan at least twice per year and failed to post an accurate daily work schedule at the beginning of each work shift. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: The licensee held an assisted living facility license effective August 1, 2025, and was licensed for a capacity of 50 residents, with a current census of 36 residents. STAFFING PLAN During the entrance conference on February 23, 2026, at 10:00 a.m., CNS-A, and licensed assisted living director (LALD)-B stated the licensee was familiar with the current minimum living requirements. In addition, they stated they had three shifts as follows: - morning shift (7:00 a.m. to 2:00 p.m.) 6 staff; - evening shift (2:00 p.m. to 10:00 p.m.) 3-4 staff;	0 470		

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0 470	Continued From page 5 and - night shift (10:00 p.m. to 7:00 a.m.) 1-2 staff. The licensee's Staffing Plan - Standard Operating Period for January 1, 2025, through December 31, 2025, noted the following: - morning shift, 3 caregivers and one supervisor; - evening shift, 2-3 caregivers; and - night shift, 1 caregiver. The previous Staffing Plan - Standard Operating Period provided was dated from January 1, 2024, through December 31, 2024. On February 24, 2026, at 12:30 p.m., LALD-B stated the staffing plan had only been done an an annual basis by the previous CNS. STAFFING SCHEDULE During the facility tour with LALD-B on February 23, 2026, at 11:40 a.m., the surveyor observed the bulletin boards in the hallway with the required postings and the posted staff schedule. The licensee's posted staff schedule titled Week 1, was dated January 26, 2026, through February 1, 2026. The posted schedule noted the following: - January 26, 2026, - morning shift included one housekeeper, one registered nurse, one administration staff, and one housekeeper/unlicensed personnel (ULP); - evening shift included two ULP; and - night shift included one ULP. On February 23, 2026, at 1:25 p.m., LALD-B stated the staff schedule is not posted each day or with the exact staffing for that day. LALD-B also stated the current posted schedule was for	0 470		

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0 470	Continued From page 6 January 26, 2026, through February 1, 2026. The licensee's Staffing & Scheduling policy dated February 8, 2024, noted the CNS would develop and implement a written staffing plan that provided an adequate number of qualified direct-care staff to meet the residents' needs, and ensure staffing levels were adequate to address each resident's needs as identified in their service plans, the acuity level as determined by the most recent assessment, and the ability of staff to meet the residents' scheduled and reasonably foreseeable unscheduled needs. It also noted the CNS would develop an 24-hour daily staffing schedule that identified the staff work schedules for each direct-care staff member showing all work shifts, days and hours worked, and the resident assignments or work location. No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	0 470		
0 510 SS=F	144G.41 Subd. 3 Infection control program (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. (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. (c) The facility must maintain written evidence of compliance with this subdivision.	0 510		

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0 510	Continued From page 7 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program to comply with accepted health care, medical, and nursing standards for infection control for one of three employees (unlicensed personnel/ULP-G). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On February 24, 2026, at 7:10 a.m., the surveyor observed ULP-G bring R2's blood glucose supplies to the counter near the dining room and observed R2 perform his blood glucose independently with ULP-G observing. R2 wiped the countertop before performing his blood glucose. However, R2 did not perform hand hygiene before or after performing his blood glucose. In addition, ULP-G did not prompt R2 to perform hand hygiene. On February 24, 2026, at 7:15 a.m., the surveyor observed ULP-G bring R9's blood glucose supplies to the counter near the dining room and observed R9 perform his blood glucose independently with ULP-G observing. R9 wiped the countertop before performing his blood glucose. However, R9 did not perform hand	0 510		

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0 510	Continued From page 8 hygiene before or after performing his blood glucose. In addition, ULP-G did not prompt R9 to perform hand hygiene. On February 24, 2026, at 7:20 a.m., ULP-G stated she usually encourages residents to perform hand hygiene before and after doing their blood glucose checks but most of the time they refuse. ULP-G stated they had hand sanitizer on the counter, but she did not prompt the residents to use it today. On February 24, 2026, at 1:30 p.m., clinical nurse supervisor (CNS)-A stated staff should encourage residents to do hand hygiene with glucose checks. The licensee's Blood Sugar Testing - Single Equipment Use policy dated February 24, 2024, noted staff were to wash their hands and have resident wash hands if possible prior to performing the blood glucose check and for staff to wash their hands after removing their gloves. The Centers for Disease Control's (CDC), "CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings" dated April 12, 2024, under section 5a.1 indicated: 1.) Require healthcare personnel to perform hand hygiene in accordance with CDC recommendations. 2.) Use an alcohol-based hand rub or wash with soap and water for the following clinical indications: a.) Immediately before touching a patient; b.) Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices; c.) Before moving from work on a soiled body site to a clean body site on the same patient;	0 510		

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0 510	Continued From page 9 d.) After touching a patient or the patient's immediate environment; e.) After contact with blood, body fluids or contaminated surfaces; and f.) Immediately after glove removal. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment 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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post in a conspicuous place, the contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities (OOMHDD) and the	0 550		

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0 550	Continued From page 10 name, telephone number, and email contact information for the individuals who were responsible for handling resident grievances. This had the potential to affect the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On February 23, 2026, at 11:40 a.m., during the facility tour with licensed assisted living director (LALD)-B, the surveyor observed the bulletin boards in the hallway with the required postings. The licensee's untitled and undated complaints form lacked: - the contact information for the OOMHDD; and - the name, telephone, and email contact information for the individuals who were responsible for handling resident grievances. On February 23, 2026, at 1:30 p.m., LALD-B stated he was unaware of the requirement to post the OOMHDD information, and was not aware the form lacked his contact information as the person responsible for handling resident grievances, but would add it to the form. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One	0 550		

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	28501	A. BUILDING: _____ B. WING _____	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOUIS HOME CARE INCORPORATED	308 1ST STREET SE LITTLE FALLS, MN 56345

(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 11 (21) days	0 550		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in and maintain documentation of quality management activity appropriate to the size and relevant to the type of services provided by the assisted living facility. This had the potential to affect the licensee's current residents. 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).	0 580		

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0 580	Continued From page 12 The findings include: During the entrance conference on February 23, 2026, at 10:00 a.m., licensed assisted living director (LALD)-B stated the licensee meets with all staff a couple times each year, and these meetings are not set, but based on what is going on, to get everyone on the same page. LALD-B stated there is no current focus or topics, but they do discuss medications including handing out, medication errors, and reporting any concerns to the nurse. The licensee's Quality Assurance Meeting Summary dated July 22, 2025, included topics discussed as quality care in medication administration, reporting concerns, person-centered care, and making every day special. The licensee's Quality Improvement Plan dated January 1, 2025, included the mission, vision, and scope of services, and noted the quality improvement activities would include: - ongoing measurement and analysis of service delivery data; and - implementation of improvement initiatives based on identified trends. The Quality Improvement plan also noted leadership would hold biannual quality improvement review meetings and develop and approve the annual quality improvement plan. It noted the goals as: - reducing missed or declined services; - reducing missed or refused medications; - reduce missed appointments; - medication error reduction; and - staff training and development.	0 580		

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0 580	Continued From page 13 On February 25, 2026, at 12:40 p.m., LALD-B stated they hold a quality improvement meeting annually with all staff. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (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. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a current facility TB risk assessment. This had the potential to affect all residents, staff and visitors.	0 660		

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0 660	Continued From page 14 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: During the entrance conference on February 23, 2026, at 10:00 a.m., licensed assisted living director (LALD)-B and clinical nurse supervisor (CNS)-A stated they believed a TB risk assessment had been completed by the previous CNS. The licensee's TB Risk Assessments dated October 18, 2023, indicated the facility was a low risk level. On February 25, 2026, at 9:55 a.m., CNS-A stated she was unable to locate a more recent TB Risk Assessment. The licensee's Tuberculosis Screening policy dated February 22, 2024, noted the licensee would maintain a current community TB risk assessment updated annually. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include an annual facility TB risk assessment.	0 660		

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0 660	Continued From page 15 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the	0 680		

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0 680	Continued From page 16 required content defined in Appendix Z. This had the potential to affect residents receiving services under the assisted living license, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On February 23, 2026, at 11:40 a.m., during the facility tour with licensed assisted living director (LALD)-B, the surveyor observed the building to have three floors, including a main floor with a common sitting area, kitchen, dining room, and resident rooms. The basement was for storage of items. The remaining floors had resident rooms. The licensee's white binder titled Disaster and Emergency Plan dated 2022, lacked the following required content: - annual update; - hazard vulnerability risk assessment (HVA); - missing resident plan reviewed quarterly; and - exercises to test the EPP at least twice per year, including unannounced staff drills using the EPP. On February 25, 2026, at 9:40 a.m., LALD-B stated the plan had not been reviewed annually, the licensee had not completed a HVA, and the missing resident plan was reviewed annually, not quarterly. In addition, LALD-B started the only drills conducted were fire drills, and he was not	0 680		

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0 680	Continued From page 17 aware other drills were required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated February 24, 2026, for the specific violations related the physical environment under Minnesota Statute 144G.	0 775		

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0 775	Continued From page 18 TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		
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 upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	0 810		

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0 810	Continued From page 19 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated February 24, 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=H	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	01290		

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01290	Continued From page 20 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 interview and record review, the licensee failed to ensure employee records contained all the required content to include a current background study (BGS) clearance letter for three of five employees (unlicensed personnel (ULP)-E, ULP-F, housekeeping (H)-D). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a 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 23, 2026, at 10:00 a.m., licensed assisted living director (LALD)-B stated the licensee was aware of the required content of the employee records. ULP-E ULP-E was hired on January 6, 2026, to provide	01290		

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01290	Continued From page 21 direct care services to residents at the facility. The licensee's untitled posted schedule for February 16, 2026, through February 22, 2026, noted ULP-E worked February 16, 2026, February 19, 2026, and February 20, 2026. ULP-E's employee record lacked a background study clearance letter. ULP-F ULP-F was hired on October 26, 2020, to provide direct care services to residents at the facility. ULP-F's employee record lacked a background study clearance letter. On February 26, 2026, at 2:25 p.m., LALD-B stated ULP-F has not worked with residents since COVID, but could be called back to work if needed. H-D H-D was hired on December 17, 2025, to provide housekeeping services at the facility. H-D's employee record lacked a background study clearance letter. The licensee's untitled posted schedule for February 16, 2026, through February 22, 2026, noted H-D worked February 18, 2026, February 21, 2026, and February 22, 2026. On February 23, 2026, at 1:38 p.m., LALD-B stated the above employees had no background study clearance letter in their records. LALD-B stated he was aware of the requirement to have a cleared background study for each employee, and the employees were provided with	01290		

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01290	Continued From page 22 information to complete the BGS but did not, and administration did not follow-up to be sure it was completed. The licensee's Background Studies policy dated February 8, 2024, indicated employees may not provide direct services or have independent direct contact with any resident until the acceptable result of the background study was received. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders;	01370		

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01370	Continued From page 23 (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care services for one of one unlicensed personnel (ULP-E). 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 23, 2026, at 10:00 a.m., licensed assisted living director (LALD)-B stated the licensee was aware	01370		

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01370	Continued From page 24 of the required contents of the employee records. ULP-E was hired on January 6, 2026, to provide direct care services to residents. ULP-E's record lacked evidence of the following required training/competency testing: - hair care and bathing; - care of teeth, gums, and oral prosthetic devices; - care and use of hearing aids; - dressing and assistance with toileting; and - standby assistance techniques and how to perform them. On February 25, 2026, at 10:10 a.m., clinical nurse supervisor (CNS)-A stated ULP-E's employee records included the forms signed by the previous CNS, but they did not indicate if ULP-E had passed the testing. The licensee's Competency Training Evaluations policy dated February 20, 2024, noted training and competency evaluations for all ULP would include: - hair care and bathing; - care of teeth, gums, and oral prosthetic devices; - care and use of hearing aids; - dressing and assistance with toileting; and - standby assistance techniques and how to perform them. The policy also noted a copy of all training and competency testing would be kept in each employee's file. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28501	A. BUILDING: _____ B. WING _____	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOUIS HOME CARE INCORPORATED	308 1ST STREET SE LITTLE FALLS, MN 56345

(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
01380	Continued From page 25	01380		
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care services for one of one unlicensed personnel (ULP-E). 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).	01380		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28501	A. BUILDING: _____ B. WING _____	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOUIS HOME CARE INCORPORATED	308 1ST STREET SE LITTLE FALLS, MN 56345

(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
01380	Continued From page 26 The findings include: During the entrance conference on February 23, 2026, at 10:00 a.m., licensed assisted living director (LALD)-B stated the licensee was aware of the required contents of the employee records. ULP-E was hired on January 6, 2026, to provide direct care services to residents. ULP-E's record lacked evidence of the following required training/competency testing: - safe transfer techniques and ambulation. On February 25, 2026, at 10:10 a.m., clinical nurse supervisor (CNS)-A stated ULP-E's employee records included the forms signed by the previous CNS, but they did not indicate if ULP-E had passed the testing. The licensee's Competency Training Evaluations policy dated February 20, 2024, noted training and competency evaluations for all ULP would include: - safe transfer techniques and ambulation. The policy also noted a copy of all training and competency testing would be kept in each employee's file. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01650 SS=E	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include:	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28501	A. BUILDING: _____ B. WING _____	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOUIS HOME CARE INCORPORATED	308 1ST STREET SE LITTLE FALLS, MN 56345

(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
01650	Continued From page 27 (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included the required content for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28501	A. BUILDING: _____ B. WING _____	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOUIS HOME CARE INCORPORATED	308 1ST STREET SE LITTLE FALLS, MN 56345

(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
01650	Continued From page 28 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: R1 R1's diagnoses included hypertension (high blood pressure) and cerebral palsy (neurological disorders affecting movement, muscle tone, and posture). R1's Service Plan dated April 29, 2025, indicated R1 received services including assistance with housekeeping, medication administration, and laundry. However, it lacked the fees for the services. R2 R2's diagnoses included schizophrenia (a severe brain disorder characterized by a distortion of reality including hallucination, delusion, and disorganized thinking) and type 2 diabetes (a chronic condition where the body resists insulin or fails to produce enough insulin, resulting in high blood sugar). On February 24, 2026, at 7:10 a.m., the surveyor observed R2 perform a blood glucose check. R2's Service Plan dated April 29, 2025, indicated R2 received services including assistance with behavior management, medication administration, and recording blood glucose twice daily. However, it lacked the fees for the services. On February 24, 2026, at 1:40 p.m., licensed assisted living director (LALD)-B stated he had	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28501	A. BUILDING: _____ B. WING _____	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOUIS HOME CARE INCORPORATED	308 1ST STREET SE LITTLE FALLS, MN 56345

(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
01650	Continued From page 29 printed out the wrong version for the residents to sign, which did not include the fees. The licensee's Service Plan policy dated February 21, 2024, noted the service plan would include the fees for services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
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: Based on observation, interview, and record review, the licensee failed to ensure an inhaler was administered per manufacturer instructions for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28501	A. BUILDING: _____ B. WING _____	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOUIS HOME CARE INCORPORATED	308 1ST STREET SE LITTLE FALLS, MN 56345

(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
01760	Continued From page 30 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included hypertension (high blood pressure) and cerebral palsy (neurological disorders affecting movement, muscle tone, and posture). On February 24, 2026, at 8:59 a.m., the surveyor observed unlicensed personnel (ULP)-G provide R1 with his Flutica-Salmet 115-21 microgram (mcg) inhaler. R1 inhaled two puffs from the inhaler independently. However, ULP-G failed to offer water or encourage R1 to rinse his mouth R1's Service Plan dated April 29, 2025, indicated R1 received services including assistance with housekeeping, medication administration, and laundry. R1's Med (Medication) Admin (Administration) Summary for February 2026, noted Flutica-Salmet 115-21 mcg daily. Inhale two puffs into the lungs twice a day for chronic obstructive pulmonary disease (COPD). It also noted "Rinse mouth after use." On February 24, 2026, at 9:04 a.m., ULP-G stated she had not offered water or encouraged R1 to rinse after use of his inhaler and added he often refused. The manufacturer's instructions for use dated	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28501	A. BUILDING: _____ B. WING _____	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOUIS HOME CARE INCORPORATED	308 1ST STREET SE LITTLE FALLS, MN 56345

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01760	Continued From page 31 August 2021, indicated "Candida albicans infection [yeast infection] of the mouth and pharynx may occur. Monitor patients periodically. Advise the patient to rinse his/her mouth with water without swallowing after inhalation to help reduce the risk." The licensee's Inhaler policy dated February 22, 2024, noted staff were to provide the resident the opportunity to rinse their mouth. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription label with legible information for five of thirty-six residents (R1, R5, R6, R7, R8) with medication 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	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28501	A. BUILDING: _____ B. WING _____	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01890	Continued From page 32 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 23, 2026, at 9:53 a.m., clinical nurse supervisor (CNS)-A and licensed assisted living director (LALD)-B stated the licensee provided medication management services to the licensee's residents. On February 24, 2026, at 1:15 p.m., the surveyor observed the medication storage room with unlicensed personnel (ULP)-G and noted the following: - R1's Flutica-Salmet inhaler lacked a prescription label; - R5's carboxymethylcellulose eye drops lacked a prescription label; - R6's Asmanex HFA inhaler lacked a prescription label; - R7's Breo Ellipta inhaler lacked a prescription label; and - R8's Spiriva Respimat inhaler lacked a prescription label. At this time, ULP-G stated no boxes for the medication was available for the medication and it must have been put in the shredding box. On February 25, 2026, at 12:45 a.m., CNS-A stated all prescription medications should have the original prescription label from the pharmacy available. No further information was provided.	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28501	A. BUILDING: _____ B. WING _____	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOUIS HOME CARE INCORPORATED	308 1ST STREET SE LITTLE FALLS, MN 56345

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01890	Continued From page 33 TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01950 SS=D	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 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 each resident and documented those instructions in the resident's record for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28501	A. BUILDING: _____ B. WING _____	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01950	Continued From page 34 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: R2's diagnoses included schizophrenia (a severe brain disorder characterized by a distortion of reality including hallucination, delusion, and disorganized thinking) and type 2 diabetes (a chronic condition where the body resists insulin or fails to produce enough insulin, resulting in high blood sugar). On February 24, 2026, at 7:10 a.m., the surveyor observed unlicensed personnel (ULP)-E bring R2's blood glucose supplies to the counter near the dining room and observed R2 perform his blood glucose independently with ULP-E observing. R2 wiped the countertop before performing his blood glucose. However, R2 did not perform hand hygiene before or after performing his blood glucose. In addition, ULP-E did not prompt R2 to perform hand hygiene. R2's Service Plan dated April 29, 2025, indicated R2 received services including assistance with behavior management, medication administration, and recording blood glucose twice daily. R2's prescriber orders dated January 7, 2026, included: - "if Blood Glucose reading is less than 70, and resident is alert and able to eat and/or drink: Give 15 grams of carbohydrate. This may be: 4 ounces (1/2 cup) of juice or regular soda, not diet. 1	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28501	A. BUILDING: _____ B. WING _____	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01950	Continued From page 35 tablespoon of sugar, honey, or corn syrup Hard candies, jellybeans, or gum drops - see food labels for how many to give. Notify the nurse. Recheck Blood Glucose in 15 minutes. If glucose is still less than 70, repeat the 15 grams of carbohydrates as above. Do not have resident eat until they feel better, follow above instructions. Recheck glucose again in 15 minutes. Notify nurse of results for further instruction. If any any point, resident becomes unconscious or is unable to eat or drink, call 911 and notify on call manager." R2's blood glucose monitoring sheet for December 1, 2025, through February 23, 2026, noted blood sugars ranging from 52 to 263 milligrams per deciliter (mg/dl). On February 24, 2026, at 1:40 p.m., clinical nurse supervisor (CNS)-A stated the staff had the parameters for low readings, but not for the high readings. CNS-A stated they usually go with anything above 400 mg/dl if the prescriber had not put the number in the order, but nothing was noted for this resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		

St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Nouis Home Care Incorporated
308 1st Street SE
Little Falls, MN 56345
Morisson County
Parcel:

Phone:
roy@nouishomecare.com

License Info

License: HFID 28501

Risk:
License:
Expires on:
CFPM: LEROY D NOUIS
CFPM #: 26499; Exp: 1/14/2029

Inspection Info

Report Number: F1037261058
Inspection Type: Full - Single
Date: 2/25/2026 Time: 11:25:51 AM
Duration: minutes
Announced Inspection: Yes
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

DISCUSSED MENU, HIGH RISK FOOD ITEMS, EMPLOYEE ILLNESS RECORDING, BARE HAND CONTACT, COOLING, REHEATING, AND DISHWASHING.

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 St Cloud District Office inspection report number F1037261058 from 2/25/2026

ROY NOUIS

Michelle Hovanes,
Public Health Sanitarian 2
320-223-7307
michelle.hovanes@state.mn.us

St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301

Temperature Observations/Recordings

Establishment Info

Nouis Home Care Incorporated
Little Falls
County/Group: Morisson County

Inspection Info

Report Number: F1037261058
Inspection Type: Full
Date: 2/25/2026
Time: 11:25:51 AM

Food Temperature: Product/Item/Unit: BEEF STEW**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 40 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: MILK**; Temperature Process:** Cold-Holding
Location: Walk-in Cooler at 40 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: SHREDDED CHEESE**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 39 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: CUT FRUIT**; Temperature Process:** Cooling
Location: Upright Cooler at 52 Degrees F.
Comment: COOLING LESS THAN 1 HOUR
Violation Issued?: No

Food Temperature: Product/Item/Unit: MARGARINE**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 35 Degrees F.
Comment:
Violation Issued?: No

St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301

Sanitizer Observations/Recordings

Establishment Info

Nouis Home Care Incorporated
Little Falls
County/Group: Morisson County

Inspection Info

Report Number: F1037261058
Inspection Type: Full
Date: 2/25/2026
Time: 11:25:51 AM

Sanitizing Chemical: **Product:** Chlorine**; Sanitizing Process:** Dish Machine
Location: Dishwashing Area **Equal To** 100 PPM
Comment:
Violation Issued?: No

Minnesota (MDH) Version
EH Manager; RPT: F1037261058

Food Establishment Inspection Report

St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301

No. of Risk Factor/Intervention/Violations	0	Date: 2/25/2026
No. of Repeat Risk Factor/Intervention/Violations		Time: 11:25:51 AM
Score (optional)		Dur: min

Establishment:	Address:	City/State:	Zip:	Phone:
Nouis Home Care Incorporated	308 1st Street SE	Little Falls, MN	56345	
License/Permit #:	**Permit Holder:**	**Purpose of Inspection:**	**Est. Type:**	**Risk Category:**
HFID 28501		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Designated compliance status (IN, OUT, N/O, N/A) for each numbered item

IN=in compliance **OUT**=not in compliance **N/O**=not observed **N/A**=not applicable

Mark "X" in appropriate box for COS and/or R

COS=corrected on-site during inspection **R**=repeat violation

	Compliance Status		COS	R
	Supervision			
1	IN	Person in charge present, demonstrate knowledge and performs duties		
2	IN	Certified Food Protection Manager		
	Employee Health			
3	IN	knowledge, responsibiities, and reporting		
4	IN	Proper use of restriction and exclusion		
5	IN	Response to vomiting, diarrheal events		
	Good Hygienic Practices			
6	IN	Proper eating, tasting, drinking, tobacco use		
7	IN	No discharge from eyes, nose, and mouth		
	Preventing Contamination by Hands			
8	IN	Hands clean and properly washed		
9	N/O	No bare hand contact with RTE foods, alternatives		
10	IN	Adequate handwashing sinks supplied and access		
	Approved Source			
11	IN	Food obtained from approved source		
12	N/O	Food Received at proper temperature		
13	IN	Food in good condition, safe & unadulterated		
14	N/A	Records available: shellstock tags, parasite dest.		
	Protection From Contamination			
15	IN	Food separated and protected		
16	IN	Food-contact surfaces; cleaned & sanitized		
17	IN	Proper Disposition of returned, previously served, reconditioned,& unsafe food		

	Compliance Status		COS	R
	Time/Temperature Control for Safety			
18	N/O	Proper cooking time & temperatures		
19	N/O	Proper reheating procedures for hot holding		
20	N/O	Proper cooling time and temperature		
21	N/O	Proper hot holding temperatures		
22	IN	Proper cold holding temperatures		
23	IN	Proper date marking & disposition		
24	N/A	Time as public health control;procedures & record		
	Consumer Advisory			
25	N/A	Consumer advisory provided for raw or undercooked foods		
	Highly Susceptible Populations			
26	IN	Pasteurized foods used; prohibited foods not offered		
	Food/Color Additives and Toxic Substances			
27	N/A	Food additives; approved & properly used		
28	N/A	Toxic substances properly identified;stored;used		
	Conformance with Approved Procedures			
29	N/A	Compliance with variance, specialized processes & HACCP plan		

Risk factors are improper practices or procedures identified as the most prevalent contributing factors of foodborne illness or injury. Public Health Interventions are control measures to prevent foodborne illness or injury

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" or OUT in box if numbered item is **not** in compliance Mark "X" in appropriate box for COS and/or R **COS**=corrected on-site during inspection **R**=repeat violation

			COS	R
		Safe Food and Water		
30	N/A	Pasteurized eggs used where required		
31		Water & ice from approved source		
32	N/A	Variance obtained for specialized processing methods		
		Food Temperature Control		
33		Proper cooling methods used; adequate equipment for temperature control		
34	N/O	Plant food properly cooked for hot holding		
35	IN	Approved thawing methods used		
36		Thermometers provided & accurate		
		Food Identification		
37		Food properly labeled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present; no unauthorized person		
39		Contamination prevented during food prep, storage, & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
		Proper Use of Utensils		
43		In-use utensils; Properly stored		
44		Utensils, equipment & linens; properly stored, dried, handled		
45		Single-use & single-service articles, properly stored and used		
46		Gloves used properly		
		Utensils, Equipment and Vending		
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, used; test strips		
49		Non-food contact surfaces clean		
		Physical Facilities		
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities; properly constructed, supplied & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing and plan review		

Person in Charge (signature)

Inspector (signature) Michele L Thomas

Follow-up: Follow-up Date:

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL28501016	**Date:** 2/24/2026
Facility Name: Nouis Home Care Incorporated	
Facility Address: 308 1st Street SE Little Falls, MN 56345	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

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

2. Egress doors shall be readily operable from the egress side without the use of a key or special knowledge. [Minn. Stat. 144G.45 subd. 2; MSFC 1010.2]

   Comments: There was employee storage and utility rooms that had a padlock on the door. The lock was not operable from inside these rooms

3. Lighted matches, cigarettes, cigars or other burning object shall not be discarded in such a manner that could cause ignition of other combustible material. [Minn. Stat. 144G.45 subd. 2; MSFC 310.7]

   Comments: There was a designated smoking area with a cigarette butt receptacle provided in front and on the North side of the building. There were cigarette ashes and butts lying on the patio and in the cracks between the north side of the building and the patio. It was also observed, in front of the building, that there were cigarette butts lying on the brick ledge and in between the cracks of the concrete patio and building.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Twenty One (21) days

1. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include employee actions to be taken in the event of a fire or similar emergency. [Minn. Stat. 144G.45 subd.2]

Comments: The licensee failed to develop the fire safety and evacuation plan (FSEP) with site specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan addressed staff as a whole with no specific direction on what staff should be doing when a fire safety emergency happens.

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

   Comments: The licensee failed to develop the fire safety and evacuation plan (FSEP) with site specific resident actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan had residents instructed to evacuate behind the nearest set of smoke compartment doors which this facility does not have.

3. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include 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. [Minn. Stat. 144G.45 subd.2]

   Comments: The licensee failed to develop the fire safety and evacuation plan (FSEP) with no unique or unusual needs for movement or evacuation for residents to take in the event of a fire or similar emergency. The plan directed staff to "remove all tenants from danger" but did not include the identification of any residents that needed assistance or any resident-specific procedures to staff for assisting residents during evacuation.