Electronically Delivered

March 17, 2026

Licensee
Birchview Gardens Assisted Living
108 3rd Street North
Hackensack, MN 56452

RE: Project Number(s) SL28209016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 13, 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.

MDH 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.

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

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 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,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 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
	28209	A. BUILDING: _____ B. WING _____	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHVIEW GARDENS ASSISTED LIV	108 3RD STREET NORTH HACKENSACK, MN 56452

(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: SL28209016-0 On February 9, 2026, through February 13, 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 thirty-six residents receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated February 10, 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 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
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. 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 that complied with accepted health care, medical and nursing standards for infection control. The deficient practice had the potential to affect all residents, employees, 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).	0 510		

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0 510	Continued From page 4 The findings include: On January 10, 2026, at 07:05 a.m., the surveyor observed unlicensed personnel (ULP)-E provide medication administration, which included oral and eye drop medication administration without performing hand hygiene when donning or doffing (putting on and taking off) gloves. ULP-E donned gloves to both hands without cleansing hands with hand sanitizer or washing hands with soap and water. ULP-E obtained a small plastic container that ULP-E had placed medications into, from the top of the medication cart. ULP-E also obtained a bottle of eye drop medication from the top of the medication cart. ULP-E locked the medication cart using their gloved right hand and proceeded to walk down the hall to R5's room. ULP-E was wearing gloves to both hands and carrying the medications, while walking down the hall. ULP-E knocked on R5's door with gloved right hand and when R5 stated to come into room, ULP-E placed their gloved right hand onto the doorknob and opened R5's door. ULP-E explained to R5 why they were in the room and placed the medications and small glass of water onto R5's walker while ULP-E opened the eye drop container that they had brought to R5 for administration. ULP-E obtained a facial tissue with their gloved right hand and proceeded to administer an eye drop to both eyes using the gloved hands to open the eyelid to each eye. Once the eye drop had been placed into the eye, ULP-E wiped both of R5's eye area with the facial tissue. ULP-E then proceeded to put the cap onto the eye drop bottle using both of their gloved hands. ULP-E obtained R5's medications and small glass of water from R5's walker with their gloved hands and proceeded to give the small glass container to R5 to place the medications into their mouth. Once the medications were in	0 510		

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0 510	Continued From page 5 R5's mouth, ULP-E gave R5 a small glass of water using their gloved hands. R5 drank the water and ULP-E verified that R5 had swallowed all of the medications. R5 gave ULP-E the empty glass of water and the small plastic container that held the medications. ULP-E placed the items into a small garbage can and doffed both gloves and placed them into the garbage can. ULP-E thanked R5 and proceeded to open the door with their ungloved right hand. ULP-E closed the door and walked down the hall to where the medication cart was located by the staff offices. ULP-E opened the computer cover and logged into the computer and documented that administration was completed for R5. ULP-E then unlocked the medication cart using their right hand and placed R5's eye drop container back into the medication cart. During this time, ULP-E did not cleanse hands with hand sanitizer or wash hands with soap and water. On January 10, 2026, at 07:25 a.m., the surveyor observed ULP-E obtain medications from the medication cart as well as a blood glucose monitor and finger lancet for R7. ULP-E sanitized both hands with hand sanitizer and began to place medications from the medications cards that held R7's medications into a small plastic container. Once ULP-E placed all of the needed medications into the small plastic container, ULP-E placed the medication cards back into the medication cart. ULP-E then sanitized hands with hand sanitizer. ULP-E then opened the zipper of the blood glucose monitor cover and obtained the blood glucose monitor. At that time R7 was waiting for ULP-E to obtain their blood glucose. ULP-E donned gloves onto both hands and removed the cover from the top of the finger lancet. ULP-E opened an alcohol wipe and placed the wipe onto R7's right ring finger.	0 510		

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0 510	Continued From page 6 ULP-E then placed the finger lancet onto R7's right ring finger and depressed the lancet causing blood to come to the surface of R7's right ring finger. ULP-E then place the blood glucose monitor to R7's right ring finger until the blood was consumed into the testing strip. ULP-E wiped R7's right ring finger with alcohol wipe and placed it into the garbage on the medication cart. ULP-E placed the finger lancet into the hazardous waste container and then doffed both gloves and placed them into the garbage can of the medication cart. ULP-E then proceeded to document the results of the blood glucose using an electronic medical record and writing the results onto a piece of paper. ULP-E cleansed both hands with hand sanitizer and proceeded to administer medications to R7. After medication administration for R7 was completed, ULP-E did not sanitize or wash hands with soap and water and proceeded to open the medication cart drawer and place blood glucose testing supplies into drawer. ULP-E then documented administration of medications using an electronic medication record. During interview on January 10, 2026, at 7:40 a.m., ULP-E stated they received infection control training from the registered nurse when they were hired which ULP-E stated included hand hygiene. ULP-E stated she felt she forgot to do hand hygiene because she was so nervous and stated she knows to always perform hand hygiene as she had been trained to do. On January 10, 2026, at 8:20 a.m., clinical nurse supervisor (CNS)-C stated all ULPs had been trained and instructed to wash hands by the registered nurse (RN) after every application of donning or doffing gloves or when completing medication administration.	0 510		

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0 510	Continued From page 7 The licensee's Hand Washing policy dated December 28, 2022, indicated hand washing would be completed before and after direct contact with a resident and after removing gloves. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
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.	0 680		

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0 680	Continued From page 8 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to review the missing person policy at least quarterly as per Minnesota Rules Chapter 4659.0110 Subpart 4. This had the potential to affect all residents, staff, and visitors of 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: The licensee's Missing Resident policy dated December 28, 2022, was included in the Emergency Preparedness (EP) plan dated as reviewed April 30, 2025. The policy lacked evidence the assisted living director and clinical nurse supervisor reviewed or updated the policy and documented any changes, at least quarterly as required. On February 10, 2026, at 1:00 p.m., clinical nurse supervisor (CNS)-C stated the missing resident policy had not been reviewed or updated quarterly as required. CNS-C indicated she was not aware that she and licensed assisted living director (LALD)-D were required to review the missing resident policy quarterly. The licensee's Missing Resident policy dated	0 680		

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0 680	Continued From page 9 December 28, 2022, indicated the licensee would review the policy at least quarterly. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0110, Subpart 4. Review missing resident plan. The assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
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	0 775		

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0 775	Continued From page 10 found to be pervasive). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated February 12, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 810 SS=E	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	0 810		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHVIEW GARDENS ASSISTED LIV	108 3RD STREET NORTH HACKENSACK, MN 56452

(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
0 810	Continued From page 11 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 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 12, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28209	A. BUILDING: _____ B. WING _____	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHVIEW GARDENS ASSISTED LIV	108 3RD STREET NORTH HACKENSACK, MN 56452

(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
01540 SS=F	144G.64 (a) (3) Training in Dementia, Mental Illness, and De- (3) for assisted living facilities with dementia care, direct-care staff must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, the staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to ensure licensed assisted living director (LALD)-D completed the required annual training related to dementia and mental health conditions. 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	01540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28209	A. BUILDING: _____ B. WING _____	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHVIEW GARDENS ASSISTED LIV	108 3RD STREET NORTH HACKENSACK, MN 56452

(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
01540	Continued From page 13 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: LALD-D began employment with the licensee on August 1, 2021. LALD-D's employment record lacked the required annual dementia and mental health training for the current training year. During interview on February 9, 2026, at 1:30 p.m., LALD-D stated his records were located off site, but he believed he was current on the required annual training related to dementia and mental health conditions. LALD-D stated he would provide the transcript to surveyor on February 10, 2026. During interview on February 10, 2026, at 10:15 a.m., both housing manager (HM)-F and LALD-D stated LALD-D did not complete the required annual dementia and mental health training for the current training year. The licensee's Dementia Training policy dated December 28, 2022, indicated all staff would complete two hours of additional training for each twelve months of work. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28209	A. BUILDING: _____ B. WING _____	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHVIEW GARDENS ASSISTED LIV	108 3RD STREET NORTH HACKENSACK, MN 56452

(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
02100	Continued From page 14	02100		
02100 SS=F	144G.82 Subd. 2 Additional requirements (a) The licensee must follow the assisted living license requirements and the criteria in this section. (b) The assisted living director of an assisted living facility with dementia care must complete and document that at least ten hours of the required annual continuing educational requirements relate to the care of individuals with dementia. The training must include medical management of dementia, creating and maintaining supportive and therapeutic environments for residents with dementia, and transitioning and coordinating services for residents with dementia. Continuing education credits may include college courses, preceptor credits, self-directed activities, course instructor credits, corporate training, in-service training, professional association training, web-based training, correspondence courses, telecourses, seminars, and workshops. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD)-D completed and documented 10 hours of annual continuing education related to the care of individuals with dementia. 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	02100		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28209	A. BUILDING: _____ B. WING _____	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHVIEW GARDENS ASSISTED LIV	108 3RD STREET NORTH HACKENSACK, MN 56452

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02100	Continued From page 15 portion or all of the residents). The findings include: LALD-D began employment with the licensee on August 1, 2021. During record review there was no documentation that LALD-D completed 10 hours of annual continuing education related to the care of individuals with dementia. During interview on February 9, 2026, at 1:30 p.m., (LALD)- stated his records were located offsite, but he believed he was completed the 10 hours of annual continuing education requirements. LALD-D stated he would provide the continuing education transcript to surveyor on February 10, 2026. During interview on February 10, 2026, at 10:15 a.m., both housing manager (HM)-F and LALD-D stated LALD-D did not complete the required 10 hours of continuing education related to the care of individuals with dementia. The licensee's Dementia Staff Training policy dated December 28, 2022, indicated the LALD would complete at least 10 hours of annual continuing education training related to the care of individuals with dementia. These 10 hours of training would be included in the LALD's annual required hours of training. Training would include medical management of dementia, creating and maintaining supportive and therapeutic environments for residents with dementia, and transitioning and coordinating services for residents with dementia. No further information was provided.	02100		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28209	A. BUILDING: _____ B. WING _____	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHVIEW GARDENS ASSISTED LIV	108 3RD STREET NORTH HACKENSACK, MN 56452

(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
02100	Continued From page 16 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02100		
02410 SS=F	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure privacy was maintained for one of one resident (R7) observed during treatment administration.	02410		

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BIRCHVIEW GARDENS ASSISTED LIV	108 3RD STREET NORTH HACKENSACK, MN 56452

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02410	Continued From page 17 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: R7 was admitted on March 22, 2022, with a diagnosis of essential hypertension and type two diabetes mellitus. R7's service agreement was dated January 30, 2026, and indicated R7 received assistance with medication administration and blood glucose monitoring. On February 10, 2026, at 7:35 a.m., R7 walked up to the medication cart, located in a common area for employees and residents, where unlicensed personnel (ULP)-E was dispensing medications. R7 asked ULP-E if she would be receiving her blood glucose test before she would be eating breakfast. ULP-E stated she would be assisting R7. On February 10, 2026, at 7:36 a.m., ULP-E gathered supplies to complete a blood glucose test for R7 (gloves, blood glucose monitor, finger lancet, alcohol wipe) and proceeded to obtain R7's blood glucose while R7 was sitting in their wheelchair next to the medication cart in the common area. During interview on February 10, 2026, at 7:45 a.m., ULP-E stated that she received medication	02410		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28209	A. BUILDING: _____ B. WING _____	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHVIEW GARDENS ASSISTED LIV	108 3RD STREET NORTH HACKENSACK, MN 56452

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02410	Continued From page 18 and treatment administration training from a registered nurse (RN). ULP-E stated it was common to complete blood glucose test and medication administration where the medication cart was located. ULP-E stated she previously would take the medication down the hall and conduct medication administration and blood glucose monitoring in resident rooms. ULP-E stated she was not sure why she stopped the past process. ULP-E stated she could not remember if this was taught to her during her training. During interview on February 10, 2026, at 8:45 a.m., R7 stated that it was common that she received her blood glucose testing at the medication cart located in the common area. During interview on February 10, 2026, at 11:10 a.m., clinical nurse supervisor (CNS)-C stated that all staff performing any task for a resident should complete the task in a private area and away from other residents or staff. CNS-C stated all staff have been educated on resident's personal privacy. The licensee's Blood Sugar Testing policy, dated December 28, 2022, did not indicate staff were to explain the procedure and provide privacy to the resident before completing a blood glucose test. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02410		

Bemidji District Office
Minnesota Department of Health
707 5th St NW, Suite A
Bemidji, MN 56601
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Birchview Gardens Assisted Living
108 3rd Street North
Hackensack, MN 56452
Cass County
Parcel:

Phone:

License Info

License: HFID 28209

Risk:
License:
Expires on:
CFPM: DAYNA M. JILLSON
CFPM #: 95901; Exp: 10/11/2027

Inspection Info

Report Number: F1040261005
Inspection Type: Full - Single
Date: 2/10/2026 Time: 11:47:18 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 1
Total Priority 3 Orders: 2
Delivery:

New Order: 4-900 Protecting Clean Items
4-903.11A *Priority Level: Priority 3 CFP#: 44*
MN Rule 4626.0955A Store all clean equipment, utensils, linens, single-service and single-use articles in a clean dry location where not exposed to splash, dust, or other contamination and at least six inches above the floor.
COMMENT: OBSERVED SINGLE-USE/SINGLE-SERVICE ITEMS SUCH AS CLAMSHELL CONTAINERS STORED ON FLOOR
Comply By: 2/17/2026 Originally Issued On: 2/10/2026

New Order: 4-900 Protecting Clean Items
4-904.11A *Priority Level: Priority 3 CFP#: 45*
MN Rule 4626.0965A Handle, display, and dispense all single-service and single use articles and clean utensils so that contamination of lip-contact and food-contact surfaces is prevented.
COMMENT: OBSERVED PLASTIC UTENSILS STORED WITH TINES/SCOOP/BLADE UP, INSTRUCTED TO STORE HANDLE UP
Comply By: 2/10/2026 Originally Issued On: 2/10/2026

New Order: 7-100 Toxic Labeling
7-102.11 *Priority Level: Priority 2 CFP#: 28*
MN Rule 4626.1595 Clearly label all working containers used for storing poisonous or toxic materials from bulk supplies such as sanitizers and cleaners, with the common name of the product.
COMMENT: OBSERVED SANITIZER SPRAY BOTTLE WITH NO LABEL, DUMPED BY ESTABLISHMENT
Comply By: Complied On Site Originally Issued On: 2/10/2026

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

I acknowledge receipt of the Bemidji District Office inspection report number F1040261005 from 2/10/2026

DAYNA

Vania Jeh,
Public Health Sanitarian 1
218-308-2124

vania.jeh@state.mn.us

Bemidji District Office
Minnesota Department of Health
707 5th St NW, Suite A
Bemidji, MN 56601

Temperature Observations/Recordings

Establishment Info

Birchview Gardens Assisted Living
Hackensack
County/Group: Cass County

Inspection Info

Report Number: F1040261005
Inspection Type: Full
Date: 2/10/2026
Time: 11:47:18 AM

Food Temperature: Product/Item/Unit: COOKED FRITO MEAL**; Temperature Process:** Cooking
Location: Stove at 165 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: COOKED REFRIED BEANS**; Temperature Process:** Cooking
Location: Stove at 155 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: 3-DOOR FREEZER, AMBIENT TEMPERATURE**; Temperature Process:** Cold-Holding
Location: Upright Freezer at 0 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: FRIDGE 3, RANCH**; Temperature Process:** Cold-Holding
Location: Cooler at 41 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: FRIDGE 2, HAM**; Temperature Process:** Cold-Holding
Location: Cooler at 41 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: FRIDGE 1, MARINARA SAUCE**; Temperature Process:** Cold-Holding
Location: Cooler at 41 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: COUNTERTOP COOLER, MILK**; Temperature Process:** Cold-Holding
Location: Countertop Cooler at 41 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: PEPSI COOLER, MILK**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 37 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: SERVING AREA FREEZER, AMBIENT TEMPERATURE**; Temperature Process:** Cold-Holding
Location: Upright Freezer at 0 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: **Product/Item/Unit:** DRY STORAGE FREEZER, AMBIENT TEMPERATURE**; Temperature Process:** Cold-Holding
Location: Upright Freezer at 0 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: **Product/Item/Unit:** DRY STORAGE CHEST FREEZER, AMBIENT TEMPERATURE**;**
Temperature Process: Cold-Holding
Location: Chest Freezer at 0 Degrees F.
Comment:
Violation Issued?: No

Bemidji District Office
Minnesota Department of Health
707 5th St NW, Suite A
Bemidji, MN 56601

Sanitizer Observations/Recordings

Establishment Info

Birchview Gardens Assisted Living
Hackensack
County/Group: Cass County

Inspection Info

Report Number: F1040261005
Inspection Type: Full
Date: 2/10/2026
Time: 11:47:18 AM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Dishwashing Area **Greater Than** 160 Degrees F.
Comment: THERMOLABEL
Violation Issued?: No

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** Wiping Cloth Bucket
Location: Kitchen **Equal To** 400 PPM
Comment:
Violation Issued?: No

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL28209016-0	**Date:** February 12, 2026
Facility Name: Birchview Gardens Assisted Living	
Facility Address: 108 3rd Street North, Hackensack, MN 56452	

☒ **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. Occupancy separation shall be provided in Group I and Group R occupancies. Existing wood lath and plaster in good condition or ½ inch gypsum wallboard is acceptable where one hour occupancy separations are required. [Minn. Stat. 144G.45 subd. 2; MSFC 1105.2]

   Comments: In the basement smoking room, there was a small hole in the ceiling. This hole shall be sealed to prevent the passage of smoke or fire to other parts of the building.

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 licensed assisted living director (LALD)-D if a remote button or switch was installed that would disengage the controlled egress locking system for the building. LALD-D stated no, and was not aware of this requirement.
   - Record review of the available documentation indicated the fire safety and evacuation plan lacked procedures for operation of the unlocking system.

4. The means of egress shall be illuminated at all times the building is occupied. [Minn. Stat. 144G.45 subd. 2; MSFC 1008]

Comments: The emergency light above the freezer in the basement storage room did not work when tested by licensed assisted living director (LALD)-D. Emergency lights shall be maintained to ensure escape routes will be illuminated during power failures or other emergencies.

5. Relocatable power taps (power strips) shall be directly connected to a permanently installed receptacle. [Minn. Stat. 144G.45 subd. 2; MSFC 604.4.2]

   Comments: In occupied resident room 106, a power strip was plugged into a yellow extension cord.

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

   Comments:
   - Extension cords were used to supply power to personal electronics in occupied resident rooms 203, 213, and 218.
   - An extension cord was used to supply power to the microwave in the employee breakroom.

7. Single- and multiple-station smoke alarms shall be replaced when they fail to respond to operability tests or exceed ten years from the date of manufacture. Smoke alarms shall be replaced with smoke alarms having the same type of power supply. [Minn. Stat. 144G.45 subd. 2; MSFC 1103.8.1]

   Comments: The smoke alarm installed in occupied resident room 103 was date stamped 2006.

8. In buildings that contain a fuel-burning appliance or fireplace, or attached private garage, carbon monoxide detection shall be installed in dwelling units within ten feet of bedrooms. Where a fuel burning appliance is located in a bedroom or its attached bathroom, carbon monoxide detection shall be installed within the bedroom. Carbon monoxide detection can be provided by carbon monoxide alarms installed in dwelling or sleeping units or a carbon monoxide detection system installed in the room or space that contains the fuel-burning appliance. [Minn. Stat. 144G.45 subd. 2; MSFC 915]

   Comments: Carbon monoxide detectors were not installed as part of the fire alarm system. Carbon monoxide alarms were not installed within 10 feet of all resident bedrooms.

☒ **TAG IDENTIFICATION: 0810**

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

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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:
- Fire safety and evacuation plan (FSEP) documents inaccurately referenced smoke compartments and fire doors on magnetic door holders. The licensee failed to develop and maintain the fire safety and evacuation plan with site specific employee actions.
- There were two FSEP 9.06 fire policies, dated December 28, 2022, and February 1, 2026. These policies included different employee actions. Licensed assisted living director (LALD)-D stated they had been working on updating the FSEP based on survey results at another location. Clear and consistent FSEP employee actions shall be maintained to avoid confusion in the event of an emergency.

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 training on the fire safety and evacuation plan completed between February 2025 and February 2026, from licensed assisted living director (LALD)-D. LALD-D stated these records were not available.

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 licensed assisted living director (LALD)-D. Record review of fire drill logs indicated drills were completed in 2025 during January, April, August, and November. Evacuation drill reports from 2026 were not provided.