Electronically Delivered

July 21, 2026

Licensee
Cornerstone Residence of Bagley
30 Sunset Avenue Southwest
Bagley, MN  56621

RE:  Project Number(s) SL30725016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 24, 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 . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

**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**

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.

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

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

HHH

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30725 | A. BUILDING: _____ B. WING _____ | 06/24/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| CORNERSTONE RESIDENCE OF BAGLEY | 30 SUNSET AVENUE SW BAGLEY, MN 56621 |

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| 0 000 | Initial Comments<br><br>*****ATTENTION*****<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.<br><br>Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.<br><br>INITIAL COMMENTS:<br><br>SL30725016-0<br><br>On June 22, 2026, through June 24, 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 34 residents; 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.<br><br>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3. | |
| 0 510 SS=D | 144G.41 Subd. 3 Infection control program<br><br>(a) All assisted living facilities must establish and | 0 510 | | |

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| 0 510 | Continued From page 1<br><br>maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control.<br>(b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities.<br>(c) The facility must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure services were provided according to accepted health care, medical, or nursing standards in regard to infection control during personal cares for one of two employees (unlicensed personnel (ULP)-D).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).<br><br>The findings include:<br><br>During the entrance conference on June 22, 2026, at 10:24 a.m., licensed assisted living director (LALD)-A stated the licensee provided assistance with activities of daily living (ADLs) services to residents at the facility. | 0 510 | | |

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| 0 510 | Continued From page 2<br><br>ULP-D's employee record indicated ULP-D was trained on understanding infection control on June 21, 2026.<br><br>On June 23, 2026, at 7:54 a.m., the surveyor observed ULP-D disconnect R8's catheter bag (collects urine draining from the bladder), threw away R8's brief into the garbage can, assisted R8 with a shower, and attached R8's leg catheter bag to R8's catheter. The surveyor did not observe ULP-D wear gloves or complete hand hygiene after removing or attaching R8's catheter bags.<br><br>On June 23, 2026, at 1:40 p.m., ULP-D stated ULP-D tried to wear gloves into resident rooms to complete cares, however, ULP-D was working a double shift due to a staff member calling in and ULP-D was running behind with cares. ULP-D further stated ULPs were trained to complete hand hygiene before and after resident cares and with glove changes.<br><br>On June 24, 2026, at 10:28 a.m., registered nurse (RN)-E stated ULPs were trained upon hire and annually regarding infection control, hand hygiene, and glove use. RN-E further stated ULPs were expected to wear gloves during catheter cares and complete hand hygiene after the task was completed.<br><br>The licensee's 8.07 Gloves policy dated August 1, 2021, indicated gloves must be worn whenever there may be direct contact between any employee and contaminated objects or as instructed.<br><br>The licensee's 8.09 Hand Washing policy dated August 1, 2021, indicated hand washing shall be completed after changing diapers (briefs) or | 0 510 | | |

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| 0 510 | Continued From page 3<br>cleaning up after someone who has used the toilet.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 510 | | |
| 0 660 SS=E | 144G.42 Subd. 9 Tuberculosis prevention and control<br><br>(a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines.<br>(b) The facility must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) and Minnesota Department of Health (MDH), including a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for two of three employees (unlicensed | 0 660 | | |

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| 0 660 | Continued From page 4<br>personnel (ULP)-D , registered nurse (RN)-E).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a 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).<br><br>The findings include:<br><br>During the entrance conference on June 22, 2026, at 10:19 a.m., licensed assisted living director (LALD)-A stated the licensee was familiar with current minimum assisted living requirements.<br><br>The licensee's Facility TB Risk Assessment Worksheet for Health Care Settings Licensed by MDH was completed on July 14, 2025, and the facility was determined to be a low risk level.<br><br>ULP-D<br>ULP-D was hired on May 1, 2024, to provide direct care services to residents at the assisted living facility.<br><br>On June 23, 2026, at 7:46 a.m., the surveyor observed ULP-d administer R6's scheduled morning medication.<br><br>ULP-D's employee record contained a negative TB screening dated May 9, 2024, a negative first-step TST administered on May 13, 2024, and read on May 15, 2024. ULP-D's second step TST was administered on July 29, 2024 (75 days after | 0 660 | | |

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| 0 660 | Continued From page 5<br><br>the first TST was read) and read on July 3, 2024 (26 days prior to the TST administration date). ULP-D's TST form indicated if the first TST results are negative, perform the second step TST in one to three weeks.<br><br>ULP-D's employee record lacked evidence of a two-step TST or other evidence of a TB screening, such as a blood draw, within 90 days of employment or upon hire.<br><br>RN-E<br>RN-E was hired on October 31, 2025, to provide direct care services to residents and supervision to the staff at the assisted living facility.<br><br>Throughout the survey June 22, 2026, through June 24, 2026, the surveyor observed RN-E provide direct care to residents at the assisted living facility.<br><br>RN-E's employee record contained a negative TB screening dated November 18, 2025, a negative first-step TST administered on November 18, 2025, and read on November 20, 2025. RN-E's second step TST was administered on June 17, 2026 (209 days after the first TST was read) and read on June 19, 2026. RN-E's TST form indicated if the first TST results are negative, perform the second step TST in one to three weeks.<br><br>RN-E's employee record lacked evidence of a two-step TST or other evidence of a TB screening, such as a blood draw, within 90 days of employment or upon hire.<br><br>On June 24, 2026, at 10:43 a.m., LALD-A stated the licensee completed the first step TST upon hire and the second step TST a "few weeks" after | 0 660 | | |

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| 0 660 | Continued From page 6<br><br>the first TST had been administered. LALD-A further stated ULP-D and RN-E's second step TSTs were not administered one to three weeks after the first step TST was read.<br><br>On June 24, 2026, at 11:27 a.m., clinical nurse supervisor (CNS)-B stated after the first TST was read, the second step TST was supposed to be administered one to three weeks later.<br><br>The licensee's 8.16 TB Screening policy dated August 1, 2021, indicated new staff will have an IGRA (Interferon-Gamma Release Assay) blood test or a two-step Mantoux (TST) conducted with results document on the Baseline TB Screening Tool for HCWs. The Baseline TB Screening Tool for HCWs indicated to perform the second step TST one to three weeks after the first negative TST.<br><br>The MDH TB Screening and Education Requirements for Assisted Living Facilities and Home Care Providers dated February 3, 2022, indicated baseline TB screening is required at the time of hire for all health care personnel in Minnesota. Baseline TB screening includes assessing for current symptoms of active TB disease; assessing TB history; and testing for the presence of infection with Mycobacterium TB by administering either a two-step TB skin test or a single TB blood test.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 660 | | |
| 0 700 SS=D | 144G.43 Subdivision 1 Resident record | 0 700 | | |

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| 0 700 | Continued From page 7<br><br>(b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to ensure resident's personal health and medical information was kept private for one of two unlicensed personnel (ULP) computers. This had the potential to affect all residents.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).<br><br>The findings include:<br><br>During the entrance conference on June 22, 2026, at 10:19 a.m., licensed assisted living director (LALD)-A stated the licensee was familiar with current minimum assisted living requirements.<br><br>On June 23, 2026, at 7:09 a.m., the surveyor observed ULP-C enter R3's apartment and left the computer screen open with resident information visible unattended in the hallway. | 0 700 | | |

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| 0 700 | Continued From page 8<br><br>On June 23, 2026, at 1:29 p.m., ULP-C stated ULPs were trained to close the computer or lock the computer screen when entering resident apartments.<br><br>On June 24, 2026, at 10:38 a.m., regional licensed assisted living director (RLALD)-G stated all computers screens were supposed to be locked when staff were not present. LALD-A further stated staff were trained to minimize the computer screen when not by the computer, so resident information was not visible.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 700 | | |
| 0 800 SS=F | 144G.45 Subd. 2 (a) (4) Fire protection and physical environment<br><br>(4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.<br><br>This MN Requirement is not met as evidenced by:<br>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 | 0 800 | | |

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| 0 800 | Continued From page 9<br>Statute 144G.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated June 23, 2026, for the specific violations related the physical environment under Minnesota Statute 144G.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 800 | | |
| 01750 SS=D | 144G.71 Subd. 7 Delegation of medication administration<br><br>When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has:<br>(1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures;<br>(2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and<br>(3) communicated with the unlicensed personnel about the individual needs of the resident. | 01750 | | |

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| 01750 | Continued From page 10<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) documented resident-specific instructions for medications for one of three residents (R4) whose medication administration was delegated to unlicensed personnel (ULP).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).<br><br>The findings include:<br><br>During the entrance conference on June 22, 2026, at 10:24 a.m., licensed assisted living director (LALD)-A stated the licensee provided medication management services to residents at the facility.<br><br>R4's diagnoses included hypothyroidism (low thyroid hormones produced), myopia (distant blurry vision), and age-related osteoporosis (weak bones).<br><br>R4's Service Plan (Private)- Addendum to Contract dated June 4, 2026, indicated R4's services included medication administration three times per day.<br><br>R4's prescriber orders dated May 22, 2026, included an order for Symbicort 160-9-4.5 | 01750 | | |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 01750 | Continued From page 11<br><br>micrograms (mcg)/actuation (ACT) inhale two puffs into lungs twice daily.<br><br>R4's Med (medication) Admin (Administration) Summary- Date Range dated May 2026, and June 2026, respectively, indicated Symbicort 160-9-4.5 mcg/ACT inhale two puffs into the lungs twice daily.<br><br>On June 23, 2023, at 7:17 a.m., the surveyor observed ULP-C administer R4's scheduled morning medications. ULP-C handed R4 the Symbicort inhaler, R4 inhaled two puffs from the Symbicort inhaler, R4 handed the Symbicort inhaler back to ULP-C, and ULP-C administered R4's oral medications with water. The surveyor did not observe ULP-C offer R4 to rinse R4's mouth and spit out the water after administration of the Symbicort inhaler.<br><br>R4's record lacked resident specific instructions for R4 to rinse mouth and spit after administration of the Symbicort inhaler.<br><br>On June 23, 2026, at 1:28 p.m., ULP-C stated the nurses wrote in specific instructions on the electronic medication administration record (EMAR), however, R4's Symbicort did not list any specific instructions.<br><br>On June 24, 2026, at 12:07 p.m., registered nurse (RN)-E stated R4's Symbicort inhaler lacked specific instructions to offer R4 to rinse out mouth and spit the water out. RN-E further stated the RN was responsible for entering specific instructions on the EMAR and R4's Symbicort inhaler was most likely a transcription error.<br><br>The manufacturer's instructions for Symbicort dated July 2019, indicated after inhalation, rinse | 01750 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30725 | A. BUILDING: _____ B. WING _____ | 06/24/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CORNERSTONE RESIDENCE OF BAGLEY | 30 SUNSET AVENUE SW BAGLEY, MN 56621 |

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|---|---|---|---|---|
| 01750 | Continued From page 12<br>mouth with water and spit the water out. Do not swallow the water.<br><br>The licensee's 7.04 Medication Management Individualized Plan policy dated April 5, 2023, indicated (licensee name) will develop and maintain a current individualized medication management record for each resident based on the resident's assessment, which included any resident-specific [sic] requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01750 | | |
| 01880 SS=D | 144G.71 Subd. 19 Storage of medications<br><br>An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure medications were secured and permitted access to only authorized personnel for four of 34 residents.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a | 01880 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 30725 | A. BUILDING: _____ B. WING _____ | 06/24/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| CORNERSTONE RESIDENCE OF BAGLEY | 30 SUNSET AVENUE SW BAGLEY, MN 56621 |

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|---|---|---|---|---|
| 01880 | Continued From page 13<br><br>resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).<br><br>The findings include:<br><br>During the entrance conference on June 22, 2026, at 10:24 a.m., licensed assisted living director (LALD)-A stated the licensee provided medication management services to residents at the facility.<br><br>During continuous observation on June 23, 2026, at 1:19 p.m., through 1:23 p.m., the surveyor observed four unknown resident medication decks (weekly medication planners used to place medications in for administration on certain days and times) sitting on an unsecured cart in the hallway outside a resident apartment on floor two. At 1:23 p.m., licensed practical nurse (LPN)-H exited the resident apartment and stated LPN-H was dropping off resident medication decks in the resident's locked medication cabinets. LPN-H further stated LPN-H was usually "in and out" of resident apartments and medications were not left in the hallway unsecured.<br><br>On June 24, 2026, at 10:28 a.m., registered nurse (RN)-E stated medications were supposed to be secured in the locked medication cart or in the resident's locked medication cabinet unless staff was present with the medications.<br><br>The licensee's 7.11 Medication Storage policy dated August 1, 2021, indicated medications managed outside of a resident's private "living space" [sic] must be securely locked in | 01880 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 30725 | A. BUILDING: _____ B. WING _____ | 06/24/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| CORNERSTONE RESIDENCE OF BAGLEY | 30 SUNSET AVENUE SW BAGLEY, MN 56621 |

| (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 |
|---|---|---|---|---|
| 01880 | Continued From page 14<br><br>substantially constructed compartments and permit only authorized personnel to have access. This may be a medication room, medication cart, or a similar setup.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01880 | | |
| 01890 SS=D | 144G.71 Subd. 20 Prescription drugs<br><br>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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription label with legible information for two of nine residents (R4, R5).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).<br><br>The findings include: | 01890 | | |

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| | 30725 | A. BUILDING: _____ B. WING _____ | 06/24/2026 |

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| CORNERSTONE RESIDENCE OF BAGLEY | 30 SUNSET AVENUE SW BAGLEY, MN 56621 |

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|---|---|---|---|---|
| 01890 | Continued From page 15<br><br>During the entrance conference on June 22, 2026, at 10:24 a.m., licensed assisted living director (LALD)-A stated the licensee provided medication management services to residents at the facility.<br><br>R4<br>On June 23, 2026, at 7:17 a.m., the surveyor observed unlicensed personnel (ULP)-C complete scheduled morning medication administration for R4, which included the administration of R4's Symbicort 160-4.5 micrograms (mcg)/actuation (act) inhaler. ULP-C stated R4's Symbicort inhaler lacked a prescription label and ULP-C was unable to locate the Symbicort box in R4's locked medication cabinet.<br><br>R5<br>On June 23, 2026, at 7:25 a.m., the surveyor observed ULP-C complete scheduled morning medication administration for R5, which included the administration of R5's budesonide/formoterol (Symbicort) 160-4.5 mcg/act inhaler. ULP-C stated R5's budesonide/formoterol inhaler lacked a prescription label and ULP-C was unable to locate the budesonide/formoterol box in R5's locked medication cabinet. ULP-C further stated R5's inhaler used to be stored in the box from the pharmacy with the prescription label.<br><br>On June 24, 2026, at 10:35 a.m., registered nurse (RN)-E stated resident's prescribed medications were supposed to be labeled with a prescription label from the pharmacy or stored in the medication box bearing a prescription label and RN-E was not sure what happened to R4 and R5's inhaler boxes. | 01890 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| 01890 | Continued From page 16<br><br>The licensee's 7.13 Medications - Prescription Drugs and Prohibition policy dated August 1, 2021, indicated when the facility receives a prescription drug, the drug must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01890 | | |
| 02320 SS=F | 144G.91 Subd. 4 (b) Appropriate care and services<br><br>(b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care medical or nursing standards for medication setup by unlicensed personnel (ULP) for two of two residents (R4, R8). In addition, the licensee failed to ensure the steps of the medication administration process was followed for one of two employees (ULP-C) observed administering medications.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or | 02320 | | |

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|---|---|---|---|---|
| 02320 | Continued From page 17<br><br>safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>During the entrance conference on June 22, 2026, at 10:24 a.m., licensed assisted living director (LALD)-A stated the licensee provided medication management services to residents at the facility.<br><br>MEDICATION SETUP<br>R4's diagnoses included hypothyroidism (low thyroid hormones produced), myopia (distant blurry vision), and age-related osteoporosis (weak bones).<br><br>R4's Service Plan (Private)- Addendum to Contract dated June 4, 2026, indicated R4's services included medication administration three times per day.<br><br>R4's prescriber orders dated May 22, 2026, included orders for amlodipine (antihypertensive) 5 milligrams (mg) twice daily, aspirin 81 mg daily, Celebrex (for arthritis) 100 mg daily, cranberry extract (supplement) 500 mg twice daily, hydroxyurea (slows cancer cell growth) 500 mg three times daily, levothyroxine (for thyroid) 88 micrograms (mcg) daily, metoprolol (antihypertensive) 25 mg daily, and oyster shell calcium (supplement) 500 mg daily.<br><br>On June 23, 2026, at 7:17 a.m., the surveyor observed ULP-C open R4's secured medication | 02320 | | |

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|---|---|---|---|---|
| 02320 | Continued From page 18<br><br>cabinet and remove a paper cup with eight medications in the paper cup. ULP-C counted the medications to verify the correct pill count and administered R4's oral medications. ULP-C stated the night staff placed R4's medications into a paper cup from R4's medication deck (weekly medication planners used to place medications in for administration on certain days and times) and brought the medication deck to the nurse's office to be refilled today (June 23, 2026).<br><br>R8<br>R8's diagnoses included hypertension (HTN- high blood pressure), gastro-esophageal reflux disease (GERD- acid reflux) and insomnia (difficulty sleeping).<br><br>R8's Service Plan (Waiver)- Addendum to Contract dated June 9, 2026, indicated R8's services included medication administration twice daily.<br><br>R8's prescriber orders day May 5, 2026, included orders for ferrous sulfate (supplement) 325 mg every other day, furosemide (for congestive heart failure) 20 mg daily, levothyroxine 75 mcg daily, metoprolol tartrate (antihypertensive) 25 mg twice daily, omeprazole (for GERD) 20 mg daily, multivitamin (supplement) daily, and vitamin c (supplement) 500 mg daily.<br><br>On June 23, 2026, at 8:14 a.m., the surveyor observed ULP-D open R8's secured medication cabinet and remove a paper cup with medications in it. ULP-D counted the medications to verify the correct pill count and administered R8's oral medications. ULP-D stated the night staff would place the morning medications into a paper cup and bring the medication decks to the nurse's office once a week for medication setups to be | 02320 | | |

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|---|---|---|---|---|
| 02320 | Continued From page 19<br>completed.<br><br>On June 23, 2026, at 10:30 a.m., licensed practical nurse (LPN)-H stated on medication setup days, the night ULPs would bring the resident's medication decks to the nurse's office to be refilled. LPN-H further stated this was the normal process the licensee used on medication setup days. Registerd nurse (RN)-E stated the licensee was aware ULPs could not set up medications for another ULP to administer.<br><br>The licensee's 7.15 Medication and Treatment-Administration and Delegation policy dated April 5, 2023, indicated the ULP must demonstrate their ability to competently follow the delegated medication administration including: complete procedure of checking a resident's medication administration record (MAR), the preparation of medication for administration, the administration of the medication to the resident, and documentation after medication administration.<br><br>MN Statute 144G.08, Subd. 41. Medication setup. "Medication setup" means arranging medications by a nurse, pharmacy, or authorized prescriber for later administration by the resident or by facility staff.<br><br>STEPS OF MEDICATION ADMINISTRATION<br>R5's diagnoses included chronic obstructive pulmonary disease (COPD- difficult breathing), hypertension, and GERD.<br><br>R5's Service Plan dated June 4, 2026, indicated R4's services included medication administration twice daily.<br><br>R5's prescriber orders dated April 1, 2026, included an order for Symbicort 160-9-4.5 | 02320 | | |

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|---|---|---|---|---|
| 02320 | Continued From page 20<br><br>micrograms (mcg)/actuation (ACT) inhale two puffs into lungs twice daily for COPD.<br><br>R5's Med (medication) Admin (Administration) Summary- Date Range dated June 2026, indicated Symbicort 160-9-4.5 mcg/ACT inhale two puffs into the lungs twice daily. Rinse and spit after.<br><br>On June 23, 2026, at 7:25 a.m., the surveyor observed ULP-C provide scheduled morning medication administration for R5. ULP-C handed R5 the Symbicort inhaler, R5 inhaled two puffs from the Symbicort inhaler, R5 handed the Symbicort inhaler back to ULP-C and applied R5's TEDS (compression stockings to increase circulation). The surveyor did not observe ULP-C offer R5 water to rinse and spit after inhalation of the Symbicort inhaler.<br><br>On June 23, 2026, at 1:28 p.m., ULP-C stated R5 did not normally rinse and spit after using R5's Symbicort inhaler.<br><br>On June 24, 2026, at 10:33 a.m., RN-E stated R5's medication administration record (MAR) had specific instructions to rinse and spit after use of the Symbicort inhaler. RN-E further stated ULPs were trained to offer to rinse and spit each time Symbicort was administered and to follow the instructions listed on the MAR.<br><br>The manufacturer's instructions for Symbicort dated July 2019, indicated after inhalation, rinse mouth with water and spit the water out. Do not swallow the water.<br><br>The licensee's 7.35 Inhaled Medications policy dated July 1, 2022, indicated after the resident has used the inhaler provide the resident the | 02320 | | |

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|---|---|---|---|---|
| 02320 | Continued From page 21<br><br>opportunity to rinse out mouth with water and spit out the water once they have rinsed.<br><br>The licensee's 7.15 Medication and Treatment-Administration and Delegation policy dated April 5, 2023, indicated an RN must specify, in writing, specific instructions for each resident and document those instructions in the residents' [sic] record. In addition, the ULP must demonstrate their ability to competently follow the delegated medication administration to a RN.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 02320 | | |

Bemidji District Office
Minnesota Department of Health
709 5th St NW, Suite A
Bemidji, MN 56601
Phone: 651-201-4500

# Food & Beverage Inspection Report



## Establishment Info

Cornerstone Residence of Bagely
30 SUNSET AVENUE SW
Bagley, MN 56621
Clearwater County
Parcel:

Phone:

## License Info

License: HFID 30725

Risk:
License:
Expires on:
CFPM: Doris Kim Kaiser
CFPM #: CFPM-50223; Exp: 01/04/2028

## Inspection Info

Report Number: F1019261051
Inspection Type: Full - Single
Date: 6/23/2026 Time: 11:59:13 AM
Duration: minutes
Announced Inspection: No
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

DISCUSSION:
MENU, CALIBRATING THERMOMETERS, FOOD STORAGE, DISH MACHINE TESTING

**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 F1019261051 from 6/23/2026**

Doris Kaiser
CFPM

Jared Morrill,
Public Health Sanitarian 3
218-308-2128
jared.morrill@state.mn.us

Bemidji District Office
Minnesota Department of Health
709 5th St NW, Suite A
Bemidji, MN 56601

# Temperature Observations/Recordings



## Establishment Info

Cornerstone Residence of Bagely
Bagley
County/Group: Clearwater County

## Inspection Info

Report Number: F1019261051
Inspection Type: Full
Date: 6/23/2026
Time: 11:59:13 AM

**Food Temperature: Product/Item/Unit:** CUCUMBER SALAD**; Temperature Process:** Cold-Holding
**Location:** REACH IN 2 DOOR COOLER at 40 F Degrees F.
Comment:
*Violation Issued?: No*

**Food Temperature: Product/Item/Unit:** CHICKEN FRIED STEAK**; Temperature Process:** Hot-Holding
**Location:** BAINE MARIE at 141 F Degrees F.
Comment:
*Violation Issued?: No*

**Food Temperature: Product/Item/Unit:** CHEESY GREEN BEANS**; Temperature Process:** Hot-Holding
**Location:** BAINE MARIE at 142 F Degrees F.
Comment:
*Violation Issued?: No*

**Food Temperature: Product/Item/Unit:** COUNTRY GRAVY**; Temperature Process:** Hot-Holding
**Location:** STOVE TOP at 143 F Degrees F.
Comment:
*Violation Issued?: No*

**Equipment Temperature: Product/Item/Unit:** REACH IN COOLER**; Temperature Process:** Cold-Holding
**Location:** at 40 F Degrees F.
Comment:
*Violation Issued?: No*

Bemidji District Office
Minnesota Department of Health
709 5th St NW, Suite A
Bemidji, MN 56601

# Sanitizer Observations/Recordings



## Establishment Info

Cornerstone Residence of Bagely
Bagley
County/Group: Clearwater County

## Inspection Info

Report Number: F1019261051
Inspection Type: Full
Date: 6/23/2026
Time: 11:59:13 AM

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

**Sanitizing Chemical:** **Product:** Quaternary Ammonia**; Sanitizing Process:** 3-Compartment Sink
**Location:** 3-Comp Sink **Equal To** 200 PPM
Comment:
*Violation Issued?: No*

Minnesota (MDH) Version
EH Manager; RPT: F1019261051

# Food Establishment Inspection Report



Bemidji District Office
Minnesota Department of Health
709 5th St NW, Suite A
Bemidji, MN 56601

| | | |
|---|---|---|
| No. of Risk Factor/Intervention/Violations | 0 | Date: 6/23/2026 |
| No. of Repeat Risk Factor/Intervention/Violations | | Time: 11:59:13 AM |
| Score (optional) | | Dur: min |

| Establishment: | Address: | City/State: | Zip: | Phone: |
|---|---|---|---|---|
| Cornerstone Residence of Bagely | 30 SUNSET AVENUE SW | Bagley, MN | 56621 | |
| **License/Permit #:** | **Permit Holder:** | **Purpose of Inspection:** | **Est. Type:** | **Risk Category:** |
| HFID 30725 | | 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 | IN | No bare hand contact with RTE foods, alternatives | | |
| 10 | IN | Adequate handwashing sinks supplied and access | | |
| | **Approved Source** | | | |
| 11 | IN | Food obtained from approved source | | |
| 12 | N/O | Food Received at proper temperature | | |
| 13 | IN | Food in good condition, safe & unadulterated | | |
| 14 | N/A | Records available: shellstock tags, parasite dest. | | |
| | **Protection From Contamination** | | | |
| 15 | IN | Food separated and protected | | |
| 16 | IN | Food-contact surfaces; cleaned & sanitized | | |
| 17 | IN | Proper Disposition of returned, previously served, reconditioned,& unsafe food | | |

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

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

## 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 | IN | 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 | IN | Plant food properly cooked for hot holding | | |
| 35 | N/O | Approved thawing methods used | | |
| 36 | | Thermometers provided & accurate | | |
| | | **Food Identification** | | |
| 37 | | Food properly labeled; original container | | |
| | | **Prevention of Food Contamination** | | |
| 38 | | Insects, rodents, & animals not present; no unauthorized person | | |
| 39 | | Contamination prevented during food prep, storage, & display | | |
| 40 | | Personal cleanliness | | |
| 41 | | Wiping cloths: properly used & stored | | |
| 42 | | Washing fruits & vegetables | | |

| | | | 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)

Follow-up: Follow-up Date:

# Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

| | |
|---|---|
| **Project No:** SL30725016-0 | **Date:** 6/23/2026 |
| **Facility Name:** CORNERSTONE RESIDENCE OF BAGLEY | |
| **Facility Address:** 30 SUNSET AVENUE SW; BAGLEY, MN 56621 | |

☒ **TAG IDENTIFICATION: 0800**

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

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

   *Comments: The wrap around porch on the north side of the facility was damaged. A vehicle struck the corner of the porch on April 21, 2026, causing damage to the finished materials of a support post and the porch guardrail. The facility owner provided documentation from their insurance company indicating that an assessment had been completed and no structural damage was identified for the support post. The facility was currently awaiting approval from the insurance company to complete the necessary repairs.*