



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

May 18, 2026

Licensee
Brookside Assisted Living
2729 State 371 Southwest
Pine River, MN 56474

RE: Project Number(s) SL30300016

Dear Licensee:

On March 24, 2026, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on September 17, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the September 17, 2025 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on September 17, 2025, found not corrected at the time of the March 24, 2026, follow-up survey and/or subject to penalty assessment are as follows:

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

0780-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (1) - \$500.00

The details of the violations noted at the time of this follow-up survey completed on March 24, 2026 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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

DOCUMENTATION OF ACTION TO COMPLY

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;

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

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

Level 4: a fine of \$3,000 per incident, in addition to any enforcement mechanism authorized in

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

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

To submit a hearing request, please visit:

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

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

We urge you to review these orders carefully. If you have questions, please contact Stephanie Jones de Palma at 651-201-4320.

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

Sincerely,

A handwritten signature in black ink, reading "Stephanie Jones de Palma". The signature is fluid and cursive, with the first name "Stephanie" being the most prominent.

Stephanie Jones de Palma, Supervisor
State Engineering Services Section
Email: stephanie.jones.de.palma@state.mn.us
Telephone: 651-201-4320 Fax: 1-866-890-9290

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30300	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 03/24/2026
NAME OF PROVIDER OR SUPPLIER BROOKSIDE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2729 STATE 371 SW PINE RIVER, MN 56474			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL30300016-2 On March 17, 2026, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on December 29, 2025. At the time of the survey, there were 11 residents; 11 receiving services under the Assisted Living Facility license. As a result of the follow-up survey, the following orders were reissued.	{0 000}			
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (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	{0 480}			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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{0 480}	Continued From page 1 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 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by:	{0 480}	Not reviewed during this survey.		

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{0 650}	Continued From page 2	{0 650}			
{0 650} SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by:	{0 650}			
{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	{0 680}	Not reviewed during this survey.		

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{0 680}	Continued From page 3 temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by:	{0 680}	Not reviewed during this survey.		
{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 and interview, the licensee failed to comply with Minnesota Fire Code, Minnesota Rules 7511. This had the potential to directly affect all building occupants.	{0 775}			

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{0 775}	Continued From page 4 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: On March 17, 2026, at 11:20 a.m., the surveyor toured the building with owner (O)-K and contractor (C)-L. During the tour, the surveyor observed the following: FIRE DOOR MAINTENANCE AND OBSTRUCTED EGRESS A fire-resistant rated door had been installed in the basement, at the bottom of the stairs, as a survey correction. - This door was part of the egress path, and a keyed cylinder case was installed above the doorknob. Egress doors shall be readily operable from the egress side without the use of a key or special knowledge. - This fire door did not self-close and latch as designed. Fire-resistant rated doors are required to be maintained where installed to prevent the spread of smoke and fire in the event of an emergency. FIRE SPRINKLER SYSTEM Sprinkler heads were visible in the building. During the building tour interview, O-K stated these sprinkler heads were not functional as the riser had been dismantled by a previous owner of the building. O-K explained a new fire	{0 775}			

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{0 775}	Continued From page 5 suppression system installation was planned for spring 2026 and the building permit application had already been submitted to Department of Labor and Industry. SMOKE ALARM MAINTENANCE - There was an empty bracket for hardwired smoke alarm in resident room 10. Hard-wired smoke alarms shall be maintained where installed with the same type of power supply. - The hardwired smoke alarm in the basement mechanical room did not work when tested. All smoke alarms must be maintained as operable. - Multiple smoke alarms were installed in the building over 10 years from date of manufacture. Smoke alarms are required to be maintained with a manufacture date of ten years or less. ELECTRICAL A yellow extension cord was attached to the wall in the basement. Extension cords shall only be used for temporary power. During the building tour interview, O-K verified the above listed observations. Observation and interview indicated the building was still not compliant on the day of the follow up. Previous survey findings: On December 29, 2025, the surveyor emailed the licensee and requested follow-up survey documentation and a plan of correction. On December 29, 2025, and December 30, 2025, the licensee responded by email with a plan of correction, records, and photos. FIRE SPRINKLER SYSTEM Fire suppression system installation planned for	{0 775}			

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{0 775}	Continued From page 6 spring 2026. A new order was identified during the survey follow-up on December 29, 2025. Record review of the available documentation indicated a fire-resistant rated door had been installed in the basement, at the bottom of the stairs, as a survey correction. This door was part of the egress path, and a keyed cylinder case was installed above the doorknob. Egress doors shall be readily operable from the egress side without the use of a key or special knowledge. On September 15, 2025, at 11:45 a.m., the surveyor toured the facility with marketing (M)-E and OC-F. During the tour, the surveyor observed the following: FIRE SPRINKLER SYSTEM Sprinkler heads were visible in the building. OC-F provided an invoice dated April 29, 2025, from a fire sprinkler inspection company. Record review indicated the company was unable to perform the inspection because the riser had been dismantled. The surveyor received an email from the licensee on September 16, 2025. The email indicated the licensee did not receive documentation from the previous owner regarding the operational history of the fire sprinkler system and the system may have been non-functional for over 15 years, dating back to when the property operated as a motel. The licensee indicated they were planning for installation of a new fire suppression system with construction anticipated to begin in spring 2026, or earlier, contingent upon the timeline for state permit approvals. Fire-extinguishing systems shall be maintained in an operative condition at all times and shall be replaced or repaired where defective. Non-required fire protection systems	{0 775}			

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{0 775}	Continued From page 7 and equipment shall be inspected, tested and maintained or removed. SMOKE ALARM MAINTENANCE - The hardwired smoke alarm in the basement mechanical room did not work when tested. All smoke alarms must be maintained as operable. - Smoke alarms installed throughout the building were over 10 years from date of manufacture. Smoke alarms are required to be maintained with a manufacture date of ten years or less. ELECTRICAL A yellow extension cord was used in the basement to supply power. Extension cords shall only be used for temporary power. During the facility tour interview, OC-F and M-E verified the above listed observations.	{0 775}			
{0 780} SS=E	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in	{0 780}			

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{0 780}	Continued From page 8 the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that complied with fire protection requirements. This had the potential to directly affect all building occupants. 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: On March 17, 2026, at 11:20 a.m., the surveyor toured the building with owner (O)-K and contractor (C)-L. During the tour, the surveyor observed the following: SMOKE ALARM INSTALLATION LOCATIONS - A smoke alarm was not installed in the sleeping room of occupied resident unit 20.	{0 780}			

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{0 780}	Continued From page 9 SMOKE ALARM INTERCONNECTION - In the basement, there were four smoke alarms installed in unoccupied resident dwelling unit 22. When the smoke alarm in the sleeping room was tested, none of the other smoke alarms in dwelling unit 22 were actuated. - On the main floor, when the battery operated wireless smoke alarms were tested, none of the hardwired smoke alarms were actuated. - On the main floor, when the smoke alarms were tested in occupied resident room 6, some of dwelling unit smoke alarms were actuated. All smoke alarms installed in the dwelling unit must be interconnected so actuation of one alarm causes all alarms in the dwelling unit to operate. During the facility tour interview, O-K and C-L verified the above listed smoke alarm observations. Observation and interview indicated the smoke alarms were still not compliant on the day of the follow up. Previous survey findings: On September 15, 2025, at 11:45 a.m., the surveyor toured the facility with marketing (M)-E and operations coordinator (OC)-F. During the tour, the surveyor observed the following: SMOKE ALARM INSTALLATION LOCATIONS - A smoke alarm was not installed in the sleeping room of occupied resident unit 20. SMOKE ALARM INTERCONNECTION - When the battery operated wireless smoke alarms were tested, none of the hardwired smoke alarms were actuated.	{0 780}			

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{0 780}	Continued From page 10 All smoke alarms installed in the dwelling unit must be interconnected so actuation of one alarm causes all alarms in the dwelling unit to operate. During the facility tour interview, M-E and OC-F verified the above listed smoke alarm observations.	{0 780}			
{0 800} SS=E	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (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. This MN Requirement is not met as evidenced by:	{0 800}			
{0 810} SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement,	{0 810}	Not reviewed during this survey.		

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{01420}	Continued From page 12 unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record. This MN Requirement is not met as evidenced by:	{01420}	Not reviewed during this survey.		
{01530} SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member	{01530}			

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NAME OF PROVIDER OR SUPPLIER BROOKSIDE ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 2729 STATE 371 SW PINE RIVER, MN 56474		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{01530}	Continued From page 13 must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by:	{01530}	Not reviewed during this survey.		
{01650} SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided;	{01650}			

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{01650}	Continued From page 14 (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by:	{01650}	Not reviewed during this survey.		
{01790} SS=D	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may	{01790}			

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{01790}	Continued From page 15 delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the	{01790}			

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{01790}	Continued From page 16 doses of each returned medication. This MN Requirement is not met as evidenced by:	{01790}	Not reviewed during this survey.		
{01880} SS=F	144G.71 Subd. 19 Storage of medications 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. This MN Requirement is not met as evidenced by:	{01880}			
{01890} SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by:	{01890}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

January 20, 2026

Licensee

Brookside Assisted Living
2729 State 371 Southwest
Pine River, MN 56474

RE: Project Number(s) SL30300016

Dear Licensee:

On December 29, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on September 17, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the September 17, 2025 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on September 17, 2025, found not corrected at the time of the December 29, 2025, follow-up survey and/or subject to penalty assessment are as follows:

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

The details of the violations noted at the time of this follow-up completed on December 29, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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 outlined on the state form; however, plans of correction are not required to be submitted for approval.

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>

We urge you to review these orders carefully. If you have questions, please contact Stephanie Jones de Palma at 651-201-4320.

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

Sincerely,

A handwritten signature in black ink, reading "Stephanie Jones de Palma". The signature is fluid and cursive, with a large, sweeping initial "S" and a long, horizontal flourish extending from the end of the name.

Stephanie Jones de Palma, Supervisor
State Engineering Services Section
Email: stephanie.jones.de.palma@state.mn.us
Telephone: 651-201-4320 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30300	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/29/2025
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{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL30300016-1 On December 29, 2025 , the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on September 17, 2025. At the time of the survey, there were 12 residents; 12 receiving services under the Assisted Living Facility license. As a result of the follow-up survey, the following order was reissued.	{0 000}			
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (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	{0 480}			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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{0 480}	Continued From page 1 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 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by:	{0 480}			
			Not reviewed during this survey.		

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{0 650}	Continued From page 2	{0 650}			
{0 650} SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by:	{0 650}			
{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	{0 680}	Not reviewed during this survey.		

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{0 680}	Continued From page 3 temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by:	{0 680}	Not reviewed during this survey.		
{0 775} SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to comply with Minnesota Fire Code, Minnesota Rules 7511. This practice resulted in a level two violation (a	{0 775}			

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{0 775}	Continued From page 4 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On December 29, 2025, the surveyor emailed the licensee and requested follow-up survey documentation and a plan of correction. On December 29, 2025, and December 30, 2025, the licensee responded by email with a plan of correction, records, and photos. EGRESS WINDOW UNOCCUPIED SLEEPING ROOM - The resident that had been living in room 22 was relocated to room 21. - A copy of the Fire Life Safety Construction plan set, signed and dated November 3, 2025, was provided. - The plan review application was submitted on November 5, 2025, to Minnesota Department of Health Engineering Services for the egress window replacement. - A copy of the Department and Labor Industry building permit, dated December 22, 2025, was provided. - A licensed contractor had been hired to complete the egress window replacement with a planned installation date of December 30, 2025. FIRE SPRINKLER SYSTEM Fire suppression system installation planned for spring 2026.	{0 775}			

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{0 775}	Continued From page 5 Record review of the available documentation indicated the egress window in unoccupied resident sleeping room 22 and fire sprinkler system, were still not compliant on the day of the follow up. Previous survey findings: EGRESS WINDOW OCCUPIED SLEEPING ROOM On September 15, 2025, at 11:45 a.m., the surveyor toured the facility with operations coordinator (OC)-F. The egress window in occupied resident sleeping room 22 was opened by OC-F and measured by the surveyor. The egress window did not meet the minimum requirements for safe egress. Egress window measurements: Occupied sleeping room 22 - the clear open area of the window measured 29.25 inches width, 18.125 inches height, with a total clear area of 530 square inches. During the facility tour interview, OC-F verified the egress window measurements. One window in each resident sleeping room must meet the minimum window opening size of at least 20 inches in width and, a minimum height of 20 inches, with a total clear area of at least 648 square inches (4.5 square feet). On September 15, 2025, at 11:45 a.m., the surveyor toured the facility with marketing (M)-E and OC-F. During the tour, the surveyor observed the following: FIRE SPRINKLER SYSTEM Sprinkler heads were visible in the building. OC-F provided an invoice dated April 29, 2025, from a fire sprinkler inspection company. Record review	{0 775}			

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{0 775}	Continued From page 6 indicated the company was unable to perform the inspection because the riser had been dismantled. The surveyor received an email from the licensee on September 16, 2025. The email indicated the licensee did not receive documentation from the previous owner regarding the operational history of the fire sprinkler system and the system may have been non-functional for over 15 years, dating back to when the property operated as a motel. The licensee indicated they were planning for installation of a new fire suppression system with construction anticipated to begin in spring 2026, or earlier, contingent upon the timeline for state permit approvals. Fire-extinguishing systems shall be maintained in an operative condition at all times and shall be replaced or repaired where defective. Non-required fire protection systems and equipment shall be inspected, tested and maintained or removed. During the facility tour interview, OC-F and M-E verified the above listed observations. A new order was identified during the survey follow-up. Record review of the available documentation indicated a fire-resistant rated door had been installed in the basement, at the bottom of the stairs, as a survey correction. This door was part of the egress path, and a keyed cylinder case was installed above the doorknob. Egress doors shall be readily operable from the egress side without the use of a key or special knowledge. TIME PERIOD FOR CORRECTION: Two (2) days	{0 775}			

Minnesota Department of Health

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{0 780}	Continued From page 7	{0 780}			
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by:	{0 780}			
{0 800} SS=E	144G.45 Subd. 2 (a) (4) Fire protection and physical environment	{0 800}	Not reviewed during this survey.		

Minnesota Department of Health

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{0 800}	Continued From page 8 (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. This MN Requirement is not met as evidenced by:	{0 800}	Not reviewed during this survey.		
{0 810} SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the	{0 810}			

Minnesota Department of Health
STATE FORM 6899 EYCE12 If continuation sheet 10 of 15

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30300	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/29/2025
NAME OF PROVIDER OR SUPPLIER BROOKSIDE ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 2729 STATE 371 SW PINE RIVER, MN 56474		
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{01420}	Continued From page 10	{01420}	Not reviewed during this survey.		
{01530} SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff	{01530}			

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{01530}	Continued From page 11 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:	{01530}	Not reviewed during this survey.		
{01650} SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned	{01650}			

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{01650}	Continued From page 12 consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by:	{01650}	Not reviewed during this survey.		
{01790} SS=D	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address:	{01790}			

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{01790}	Continued From page 13 (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by:	{01790}			
{01880} SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments	{01880}	Not reviewed during this survey.		

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{01880}	Continued From page 14 according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by:	{01880}	Not reviewed during this survey.		
{01890} SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by:	{01890}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 31, 2025

Licensee
Brookside Assisted Living
2729 State 371 Sw
Pine River, MN 56474

RE: Project Number(s) SL30300016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 17, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;

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

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

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

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

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

pursuant to this survey:

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - \$1,000.00

St - 0 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - \$500.00

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$2,500.00**. 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,

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

Jessie Chenze, Supervisor

State Evaluation Team

Email: Jessie.Chenze@state.mn.us

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

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30300	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/17/2025
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0 000	Initial Comments 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: SL30300016-0 On September 15, 2025, through September 17, 2025, the Minnesota Department of Health conducted a change of ownership (CHOW) survey at the above provider. At the time of the survey, there were 11 residents; 11 receiving services under the Assisted Living Facility license. An immediate correction order was identified on September 16, 2025, for correction order tag identification 1290, issued at a level and scope of level three, widespread (I).	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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

Minnesota Department of Health

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: 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 September 16, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480			

Minnesota Department of Health

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0 480	Continued From page 3	0 480			
	TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.				
0 650 SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records contained the required content for one of three employees (clinical nurse supervisor (CNS)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 650			

Minnesota Department of Health

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0 650	Continued From page 4 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on September 15, 2025, at 10:30 a.m., regional registered nurse (RRN)-C stated the licensee was aware of required content in an employee record. CNS-B was hired January 26, 2024, and provided supervision of staff and provided direct care services to the residents. CNS-B's's record lacked evidence an annual performance review that defined areas of improvement needed and training needs had been completed. On September 16, 2025, at 4:02 p.m., RRN-C stated RRN-C was unable to find a performance review for CNS-B. RRN-C stated the old director must have missed completing CNS-B's annual review. The licensee's 4.05 Employee Records policy dated March 1, 2025, indicated employee records for each person will include documentation of annual performance reviews that identify areas of improvement needed or training needs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			

Minnesota Department of Health

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0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. In addition, the licensee failed to ensure the missing resident plan was reviewed quarterly. This had the potential to affect all residents, staff, and visitors of the facility.	0 680			

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0 680	Continued From page 6 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: During the entrance conference on September 15, 2025, at 10:30 a.m., regional registered nurse (RRN)-C stated the licensee was familiar with the current minimum assisted living requirements. The licensee's EPP plan last reviewed March 2025 provided to the surveyor included generic instructions for staff to follow in case of natural disasters, evacuation and shelter in place plans. The licensee's EPP did not include the following: - a hazard and vulnerability assessment - a quarterly review of the missing resident policy (last reviewed March 2025) - a description of the facilities approach to meeting the health/safety/security needs of the staff and residents; - process for EP cooperation with state and local EP officials/organizations; - a description of the population served by the licensee; - development of policies/procedures to address: - procedure for tracking staff and residents; - subsistence needs for staff and residents during an emergency to include (food, water, medical supplies, pharmacy supplies, sewer and waste disposal, emergency lighting, fire detection, extinguishing and alarm systems); - evacuation plan which included staff	0 680			

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0 680	Continued From page 7 responsibilities during an evacuation and transporting services for residents being evacuated; - a medical record documentation system to preserve resident information, security, and availability; - emergency staffing strategies to include volunteers; - the development of arrangements with other facilities and providers to receive residents if needed; and - the facilities role in providing care and treatment at alternative sites under a 1135 waiver; - a communication plan that included: - names and contact information for staff, entities providing services under arrangement, resident physicians, other facilities, volunteers; - arrangement with other facilities; - contact information for federal, state, tribal, local EP staff, ombudsman, state licensing and certification agencies; - primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management agencies; - a method of sharing information and medical documentation for residents; and - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy. On September 16, 2025, at 4:10 p.m., RRN-C stated RRN-C was aware the EPP was missing required content and was not site specific. RRN-C further stated the missing resident policy was reviewed quarterly at staff meetings, and thought it was documented; however, the surveyor did not receive documentation of the meetings.	0 680			

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0 680	Continued From page 8 The licensee's Missing Resident Policy dated March 2025, indicated [facility] will review this policy and any individual resident plans that pertain to elopement at least quarterly, and all changes will be documented. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0110, Subp. 4, effective October 2022, the assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0100, sections A and B, effective October 2022, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 775 SS=I	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:	0 775			

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0 775	Continued From page 9 This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to comply with Minnesota Fire Code, Minnesota Rules 7511. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a 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: EGRESS WINDOW OCCUPIED SLEEPING ROOM On September 15, 2025, at 11:45 a.m., the surveyor toured the facility with operations coordinator (OC)-F. The egress window in occupied resident sleeping room 22 was opened by OC-F and measured by the surveyor. The egress window did not meet the minimum requirements for safe egress. Egress window measurements: Occupied sleeping room 22 - the clear open area of the window measured 29.25 inches width, 18.125 inches height, with a total clear area of 530 square inches. During the facility tour interview, OC-F verified the egress window measurements. One window in each resident sleeping room must meet the minimum window opening size of at least 20 inches in width and, a minimum height of 20 inches, with a total clear area of at least 648 square inches (4.5 square feet).	0 775			

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0 775	Continued From page 10 On September 15, 2025, at 11:45 a.m., the surveyor toured the facility with marketing (M)-E and OC-F. During the tour, the surveyor observed the following: EGRESS DOOR LOCKING Battery operated keypad locks were installed on the emergency exit door for the main entrance and on the exit door located at the side of the building adjacent to resident rooms 6 and 7. During the tour, the surveyor requested that these doors be unlocked. A code entered into the keypad was required to unlock these doors. The exit door leading out to the deck from the commons had two keypad locks installed and required use of a key to unlock. Additionally, hasp latching hardware was installed near the top of this exit door. Record review indicated the fire sprinkler system was not operable and there was not an automatic fire alarm system. During the facility tour interview, M-E and OC-F stated they believed these emergency exit doors would not unlock upon loss of power. Emergency exit doors are required to open with a single action and without the use of keys, tools, or special knowledge. Any egress door in a locked facility must interconnect with the fire safety systems and default to an unlocked position under activation of the fire alarm, fire sprinkler system, or a loss of power. Emergency exit door locking systems are required to comply with MSFC in Minnesota Rules Chapter 7511. OBSTRUCTED EGRESS - The egress window in occupied resident sleeping room 22 was obstructed by a window air conditioner unit and the storage of personal items in front of the window. - An exterior gate leading to the public way was	0 775			

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0 775	Continued From page 11 installed on the deck at the main facility entrance. A latching style lock was installed on the exterior side of the gate (non-exit side) and was not readily visible. All paths of egress must provide unobstructed exiting. FIRE SPRINKLER SYSTEM Sprinkler heads were visible in the building. OC-F provided an invoice dated April 29, 2025, from a fire sprinkler inspection company. Record review indicated the company was unable to perform the inspection because the riser had been dismantled. The surveyor received an email from the licensee on September 16, 2025. The email indicated the licensee did not receive documentation from the previous owner regarding the operational history of the fire sprinkler system and the system may have been non-functional for over 15 years, dating back to when the property operated as a motel. The licensee indicated they were planning for installation of a new fire suppression system with construction anticipated to begin in spring 2026, or earlier, contingent upon the timeline for state permit approvals. Fire-extinguishing systems shall be maintained in an operative condition at all times, and shall be replaced or repaired where defective. Non-required fire protection systems and equipment shall be inspected, tested and maintained or removed. FIRE DOOR MAINTENANCE In the basement, at the bottom of the stairs, there was a door frame with a 20 minute fire label. The fire door had been removed and was located in an exterior shed on the property. Fire-resistant rated doors are required to be	0 775			

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0 775	Continued From page 12 maintained where installed to prevent the spread of smoke and fire in the event of an emergency. SMOKE ALARM MAINTENANCE - There were several empty brackets for hardwired smoke alarms in the building. Hard-wired smoke alarms shall be maintained where installed with the same type of power supply. - The hardwired smoke alarm in the basement mechanical room did not work when tested. All smoke alarms must be maintained as operable. - Smoke alarms installed throughout the building were over 10 years from date of manufacture. Smoke alarms are required to be maintained with a manufacture date of ten years or less. CARBON MONOXIDE DETECTION Carbon monoxide alarms were not installed outside and within ten feet of all sleeping rooms. COMBUSTIBLE STORAGE In occupied resident unit 22, combustible items were stored on top of the stove, creating a fire hazard. SMOKING MATERIAL DISPOSAL Burnt cigarettes were disposed of in a covered plastic garbage can stored on the patio outside resident unit 22. Several burnt cigarettes had been disposed of on the ground in the yard and on the floor of the front deck. Smoking materials shall be discarded into approved style non-combustible containers. CLOTHES DRYER MAINTENANCE There was an accumulation of lint behind the clothes dryer in the main floor laundry room, creating a fire hazard.	0 775			

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0 775	Continued From page 13 ELECTRICAL A yellow extension cord was used in the basement to supply power. Extension cords shall only be used for temporary power. During the facility tour interview, OC-F and M-E verified the above listed observations. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775			
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;	0 780			

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0 780	Continued From page 14 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that complied with fire protection requirements. This had the potential to directly affect all building occupants. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 15, 2025, at 11:45 a.m., the surveyor toured the facility with marketing (M)-E and operations coordinator (OC)-F. During the tour, the surveyor observed the following: SMOKE ALARM INSTALLATION LOCATIONS - A smoke alarm was not installed in the sleeping room of occupied resident unit 20. - A smoke alarm was not installed outside and in the immediate vicinity of resident sleeping rooms 1 and 10. - A smoke alarm was not installed outside and in the immediate vicinity of resident units 20 and 21. SMOKE ALARM INTERCONNECTION - When the battery operated wireless smoke alarms were tested, none of the hardwired smoke	0 780			

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0 780	Continued From page 15 alarms were actuated. - When the smoke alarms installed in the basement were tested, none of the smoke alarms on the main floor were actuated. - When the battery wireless smoke alarms on the main floor were tested, none of the smoke alarms in the basement were actuated. All smoke alarms installed in the dwelling unit must be interconnected so actuation of one alarm causes all alarms in the dwelling unit to operate. - The wireless battery operated smoke alarms installed in occupied resident sleeping rooms 2, 7, and 9 on the main floor were not actuated when the wireless smoke alarm system was tested. This was corrected on September 15, 2025, while the surveyor was onsite. During the facility tour interview, M-E and OC-F verified the above listed smoke alarm observations. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780			
0 800 SS=E	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (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.	0 800			

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0 800	Continued From page 16 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all building occupants. 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: On September 15, 2025, at 11:45 a.m., the surveyor toured the facility with marketing (M)-E and operations coordinator (OC)-F. During the tour, the surveyor observed the following: - In occupied resident unit 22, there were soiled floor and bathroom surfaces. The cover was missing for the light fixture in the bedroom closet. - The door for the basement laundry room had been removed. - In the basement cleaning supplies closet, ceiling tiles were damaged. - In occupied resident unit 20, one section of base trim was missing between the floor and wall in the bathroom. - In unoccupied resident unit 21, the cover was missing from the light/exhaust fan above the bathroom shower.	0 800			

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0 800	Continued From page 17 - The exhaust fan cover was missing in the employee restroom. - There was overgrown vegetation on one of the walkways for the exterior deck at the front of the building. - The finish on the surface of the exterior deck was worn off in multiple locations. During the facility tour interview, M-E and OC-F verified the above listed observations. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to	0 810			

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0 810	Continued From page 18 include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with required content, and provide required training and drills. This had the potential to directly affect all building occupants. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 15, 2025, marketing (M)-E and operations coordinator (OC)-F provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN	0 810			

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0 810	Continued From page 19 The licensee FSEP failed to identify the location of all resident sleeping rooms. On September 15, 2025, at 11:45 a.m., the surveyor toured the facility with M-E and OC-F. During the tour, the surveyor observed the following: - Occupied resident room 1 was not identified on the posted FSEP floor plan. - The posted room number for occupied resident room 1 was not visible. - The numbers posted on the resident room doors in the basement did not match the number labels on the posted FSEP floor plan. During the facility tour interview, M-E and OC-F verified the above listed observations. Record review of the available documentation indicated the licensee failed to develop and maintain the FSEP with site specific procedures for the facility and building occupants. The FSEP had been created using templates from third party providers evident by the following: - The undated Brookside fire safety and evacuation plan in the emergency preparedness binder referenced smoke compartments, but these areas were not identified. The plan inaccurately referenced an addressable fire alarm system with automatic smoke detection, smoke and fire barrier doors with electromagnetic door holders, and an automatic dialer that notifies the alarm monitoring company. Employees were inappropriately directed that evacuation of the entire building will be done only upon orders from the administration or fire department, in a building with a non-operational fire sprinkler system. - The FSEP included standard employee procedures, but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building	0 810			

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0 810	Continued From page 20 layout and environmental risks. . - The FSEP failed to include fire safety and evacuation instructions for residents evident by a lack of these procedures in the plan. - The FSEP included standard resident evacuation procedures, but failed to provide site specific actions for resident movement and evacuation. - Record review indicated residents were assigned numbers that corresponded with evacuation levels, but procedures for the individualized unique evacuation needs of residents were not included in the FSEP. During an interview on September 15, 2025, at 3:45 p.m., M-E and OC-F verified the FSEP required revision. TRAINING Record review indicated the licensee failed to provide training to employees on the site specific FSEP at the time of hire. New hire employee records for fire safety and evacuation training from an online third party training platform were provided. During an interview on September 15, 2025, at approximately 3:15 p.m., M-E verified records for site specific FSEP training were not available. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month evident by a review of fire drill reports lacking the required frequency and documentation. One fire drill report, dated March 19, 2025, and two undated signature pages were provided.	0 810			

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0 810	Continued From page 21 During an interview on September 15, 2025, at 3:45 p.m., M-E and OC-F verified the evacuation fire drill frequency and documentation were lacking. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure current employee records contained all the required content to include a current background study (BGS) clearance letter for one of eight employees (unlicensed personnel (ULP)-G). This had the potential to affect all residents living within the facility.	01290			

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01290	Continued From page 22 This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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: This resulted in an immediate correction order on September 16, 2025. During the entrance conference on September 15, 2025, at 10:30 a.m., regional registered nurse (RRN)-C stated the licensee was aware of required contents in an employee record. ULP-G -was hired on March 24, 2014, and began to provide direct care services to the assisted living residents on August 2, 2024. The licensee's staff schedule indicated ULP-G worked unsupervised on September 13, 2025, and was scheduled to work September 20, 2025. ULP-G's employee record lacked a current BGS. On September 16, 2025, at 11:25 a.m., marketing director (MD)-E stated ULP-G was not on the NetStudy 2 roster printed September 15, 2025. MD-E stated the past licensed assisted living director (LALD) had worked on updating ULP-G's BGS in February 2025, however, was not sure what happened. MD-E stated NetStudy 2 indicated she was in "queue" and had called NetStudy, however, MD-E had not heard back yet.	01290			

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01290	Continued From page 23 The licensee's 4.02 Background Studies policy dated March 1, policy indicated [facility name] will conduct a Minnesota Department of Human Services Background Study on all employees and volunteers and contractors at [facility name]. No employee may provide direct services and have independent direct contact with any residents until acceptable results of the background study have been received. Continuous Direct Supervision defined in NETStudy 2.0 System User Manual Updated July 7, 2023, page 7: Continuous, Direct Supervision - An individual is within sight or hearing of the program's supervising individual to the extent that the program's supervising individual is capable at all times of intervening to protect the health and safety of the persons served by the program. Direct Contact Services - Providing face-to-face care, training, supervision, counseling, consultation, or medication assistance to persons served by the entity. Supervision defined in, NETStudy 2.0 System User Manual Updated July 7, 2023, page 53: Supervision Status Study subjects must be under continuous, direct supervision until the study subject is determined eligible of until the entity is notified by Department of Human Services (DHS) that the study subject may provide unsupervised services while the background study is being completed. The supervision status is shown in the "Supervision Required" column for convenience. However, programs are instructed to rely on background study notices for supervision status and other background study determination information. No further information was provided.	01290			

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01290	Continued From page 24	01290			
	TIME PERIOD FOR CORRECTION: Immediate				
01420 SS=D	144G.62 Subd. 2 Delegation of assisted living services (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If the unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) specified in writing, instructions in the resident record for delegated tasks provided by unlicensed personnel (ULP) for one of three residents (R2) who received catheter cares. 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	01420			

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01420	Continued From page 25 limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's diagnoses included hypertension (high blood pressure), depression, and overactive bladder. On September 16, 2025, at 8:35 a.m., the surveyor observed unlicensed personnel (ULP)-G empty R2's catheter bag. R2's 90-day Uniform Assessment Review dated August 5, 2025, indicated R2 had a Foley catheter (a thin, flexible tube inserted into the bladder to drain urine) for incontinence. R2's service recap summary dated August 1, 2025, through September 15, 2025, indicated R2 received catheter cares four times a day. R2's service plan dated August 1, 2024, indicated R2 received medication administration, assistance with bathing, dressing, mobility, vital signs, housekeeping and laundry. R2's record lacked specific written instructions for catheter cares or when to contact an RN should problems arise. On September 16, 2025, at 4:11 p.m., regional registered nurse (RRN)-C stated she was unsure if R2's record included specific written instructions for R2's catheter cares and would email (electronic mail) the surveyor if found. The licensee's 6.14 Delegation of Assisted Living Services policy dated March 1, 2023, indicated the RN or licensed health professional will	01420			

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01420	Continued From page 26 document instructions for the delegated tasks in the resident record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01420			
01530 SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation	01530			

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01530	Continued From page 27 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 observation, interview, and record review, the licensee failed to ensure direct care staff received the required two hours of initial training on mental illness and de-escalation topics for two of two employees (clinical nurse supervisor (CNS)-B, unlicensed personnel (ULP)-G). This had the potential to affect all residents and staff. 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: During the entrance conference on September 15, 2025, at 10:30 a.m., regional registered nurse (RRN)-C stated the licensee was familiar with the current minimum assisted living requirements.	01530			

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01530	Continued From page 28 CNS-B CNS-B was hired January 26, 2024, and provided supervision of staff and provided direct care services to the residents. CNS-B's record indicated CNS-B completed 0.75 hours of mental illness training on January 23, 2024. CNS-B lacked 1.25 hours of the two hours of initial training on mental illness and de-escalation topics which became effective July 1, 2025. ULP-G ULP-G was hired November 1, 2023, to provide direct care services to the residents of the facility. On September 16, 2025, at 6:55 a.m., the surveyor observed ULP-G administer R1's scheduled morning medications. ULP-G's records lacked documentation ULP-G completed the required two hours of initial training on mental illness and de-escalation topics which became effective July 1, 2025. On September 16, 2025, at 4:05 p.m., regional registered nurse (RRN)-C stated the licensee used two education online platforms for training. RRN-C stated annual training was completed each year by hire date. RRN-C further stated the mental health and de-escalation training was assigned, however, the completion training date of July 1, 2025, was not added to the staff training. The licensee's 5.03 Dementia Training policy dated March 1, 2025, indicated direct care staff and supervisors must satisfy eight hours of initial training for dementia, however, the policy did not	01530			

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01530	Continued From page 29 include two hours of mental health and de-escalation training to be completed by July 1, 2025. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			
01650 SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those	01650			

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01650	Continued From page 30 chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included the required content for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: During the entrance conference on September 15, 2025, at 10:30 a.m., regional registered nurse (RRN)-C stated the registered nurse (RN) develop and maintain the service plans. R2's diagnoses included hypertension (high blood pressure), depression, and overactive bladder. On September 16, 2025, at 8:35 a.m., the surveyor observed unlicensed personnel (ULP)-G empty R2's catheter bag. R2's 90-day Uniform Assessment Review dated August 5, 2025, indicated R2 had a Foley catheter (a thin, flexible tube inserted into the bladder to drain urine) for incontinence. R2's service recap summary dated August August 1, 2025, through September 15, 2025, indicated	01650			

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01650	Continued From page 31 R2 received catheter cares four times a day. R2's service plan dated August 1, 2024, indicated R2 received medication administration, assistance with bathing, dressing, mobility, vitals signs, housekeeping and laundry. R2's service plan lacked catheter cares four times a day. On September 16, 2025, at 4:12 p.m., RRN-C stated R2's service plan did not include catheter cares. RRN-C stated R2's service plan was not updated and thinks the nurse may have forgotten. The licensee's Service Plan policy dated March 1, 2025, indicated all residents receiving assisted living services will have a service plan in place. A service plan will include a description of the services that are to be provided based on the most recent assessment and resident preferences. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650			
01790 SS=D	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special	01790			

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01790	Continued From page 32 instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the	01790			

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01790	Continued From page 33 designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one unlicensed personnel (ULP-G) was trained by a registered nurse (RN) and had demonstrated competency to prepare and give medications for residents having unplanned time away. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-G was hired November 1, 2023, to provide direct care services to the residents of the facility. On September 16, 2025, at 6:55 a.m., the surveyor observed ULP-G administer R1's scheduled morning medications. ULP-G's employee record lacked evidence to	01790			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30300	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/17/2025
NAME OF PROVIDER OR SUPPLIER BROOKSIDE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2729 STATE 371 SW PINE RIVER, MN 56474			
(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
01790	Continued From page 34 indicate ULP-G had demonstrated competency to provide medications to residents for unplanned times away from home. On September 16, 2025, at 2:00 p.m., regional registered nurse (RRN)-I stated RRN-I was unsure if ULP-G was trained and had a competency completed to prepare and give medications to residents for unplanned times away. On September 16, 2025, at 4:15 p.m., RRN-C, (another RRN at the facility) stated RRN-C was unable to find ULP-G's training and competency for unplanned times away. The licensee's Medication Administration-Planned and Unplanned Time Away policy dated April 2, 2025, indicated for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or properly trained and competency tested unlicensed personnel may give the client or client's representative medications in amounts and dosages needed for the anticipated absence. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790			
01880 SS=F	144G.71 Subd. 19 Storage of medications 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.	01880			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30300	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/17/2025
NAME OF PROVIDER OR SUPPLIER BROOKSIDE ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 2729 STATE 371 SW PINE RIVER, MN 56474		
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01880	Continued From page 35 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure refrigerated medications were maintained at manufacturer recommended temperatures by failing to monitor medication refrigerator temperatures for the medication refrigerator. 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 the residents). The findings include: On September 15, 2025, at 12:05 p.m., the surveyor reviewed the locked medication refrigerator with regional registered nurse (RRN)-C and observed the temperature to read 34 degrees Fahrenheit (F). The following medications were stored in the refrigerator: -six unopened Novolog (rapid acting) insulin pens; and -one Vivitrol (treats substance abuse disorders) vial. The licensee's medication refrigerator temperature logs (which did not indicate the desired temperature) for the medication refrigerator dated August 1, 2025, through September 14, 2025, indicated the following: -temperatures read between 29 F to 32 F, 29 days out of 31 days for the month of August 2025 (two dates not documented); and	01880			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30300	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/17/2025
NAME OF PROVIDER OR SUPPLIER BROOKSIDE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2729 STATE 371 SW PINE RIVER, MN 56474			
(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 36 -temperatures read between 29 F to 32 F, for the 14 days in September 2025. On September 15, 2025, at 12:07 a.m., unlicensed personnel (ULP)-D stated the medication refrigerator should be between 30 F to 34 F. RRN-C stated she was unsure of the desired temperature for the medication refrigerator and would need to check. On September 16, 2025, at 4:02 p.m., RRN-C stated the temperature should have been between 36 to 46 F and the medication refrigerator temperature was to cold. RRN-C further stated the temperature log should have indicated the desired temperature of the medication refrigerator. The manufacturer's instructions for Novolog insulin pen dated November 2021, directed to keep new Novolog insulin pens in the refrigerator between 35 F to 46 F. The manufacturer's instructions for Vivitrol injectable suspension dated October 2010, directed to keep new Vivitrol stored in the refrigerator between 35 F to 46 F. Vivitrol should not be frozen. The licensee's 7.11 Medication Storage policy, dated March 1, 2025, indicated medications would be stored consistent with manufacturer's recommendations (refrigerated, room temperature or frozen). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30300	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/17/2025
NAME OF PROVIDER OR SUPPLIER BROOKSIDE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2729 STATE 371 SW PINE RIVER, MN 56474			
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01890	Continued From page 37	01890			
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription label with legible information including the expiration date for time sensitive medications for three of three residents (R1, R6, R7), and failed to ensure nursing supplies were not expired. 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 the residents). The findings include: During the entrance conference on September 15, 2025, at 10:30 a.m., regional registered nurse (RRN)-C stated the licensee provided medication management services to the residents at the facility. On September 15, 2025, at 12:10 p.m., the	01890			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30300	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/17/2025
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01890	Continued From page 38 surveyor observed the medication storage room with RRN-C and RRN-I (another RRN at the facility) and observed the following: Lacked Expiration Dates and Pharmacy Labels -R1's opened Novolog (treats high blood sugars) insulin pen lacked an expiration date; -R6's opened Latanoprost (treats eye pressure) 0.0005% eye drop bottle lacked expiration date; and -R7's opened dorzolamide hydrochloride (treats eye pressure) 2% eye drop lacked a pharmacy label and expiration date and one unopened dorzolamide hydrochloride lacked a pharmacy label. Expired Supplies -two opened Hydrogen Peroxide bottles, expired January 2023 and February 2023; -one opened hydrocortisone cream, expired July 2025; -one opened methyl salicylic (relieves minor pain) 30% cream expired November 2024; and -one bottle of sport ultra sunscreen expired January 2024. On September 15, 2025, at 12:12 p.m., unlicensed personnel (ULP)-D stated R1's opened Novolog insulin pen could be used until the manufacturer expiration date. ULP-D further stated R7's family would bring R7's eye drops, which the staff would give to the nurse, and the nurse would check it and place in R7's medication box. On September 15, 2025, at 12:25 p.m., RRN-I stated medications should have pharmacy labels and be labeled with expiration dates if the medication is time sensitive. RNN-I stated supplies that were expired should have been	01890			

Minnesota Department of Health

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01890	Continued From page 39 discarded. The manufacturer's instructions for Novolog insulin pen dated November 2021, indicated to discard the Novolog insulin pen 28 days after opening, even if the insulin pen still contains Novolog. The manufacturer's instructions for the use of Latanoprost eye drops dated March 2022, indicated to discard Latanoprost eye drops six weeks after opening, even if the bottle still contains Latanoprost. The licensee's 7.11 Medication Storage policy dated March 1, 2025, indicated medications will be stored per manufacturer's directions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			



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

Food & Beverage Inspection Report

Page: 1

Establishment Info

Brookside Assisted Living
2729 State 371 SW
Pine River, MN 56474
Cass County
Parcel:

Phone:

License Info

License: HFID 30300

Risk:
License:
Expires on:
CFPM:
CFPM #: ; Exp:

Inspection Info

Report Number: F1040251056
Inspection Type: Full - Single
Date: 9/16/2025 Time: 10:00:41 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 4
Total Priority 3 Orders: 1
Delivery:

New Order: 2-100 Supervision

2-102.12AMN Priority Level: Priority 3 CFP#: 2

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

COMMENT: AT TIME OF INSPECTION NO CFPM

Comply By: 11/11/2025 Originally Issued On: 9/16/2025

New Order: 2-300 Personal Cleanliness

2-301.15 Priority Level: Priority 2 CFP#: 8

MN Rule 4626.0080 Employees must wash their hands in a handwashing sink. Discontinue using the following sinks for handwashing: sinks used for food preparation or warewashing or a service sink or a curbed cleaning basin used for the disposal of mop water.

COMMENT: AT TIME OF INSPECTION NO SINK DESIGNATED HANDWASHING ONLY

Comply By: 9/16/2025 Originally Issued On: 9/16/2025

New Order: 4-300 Equipment Numbers and Capacities

4-302.12B Priority Level: Priority 2 CFP#: 36

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

COMMENT: AT TIME OF INSPECTION NO THIN TIP THERMOMETER AVAILABLE

Comply By: 9/23/2025 Originally Issued On: 9/16/2025

New Order: 4-300 Equipment Numbers and Capacities

4-302.14 Priority Level: Priority 2 CFP#: 48

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

COMMENT: AT TIME OF INSPECTION NO QUATERNARY TEST STRIPS AVAILABLE

Comply By: 9/23/2025 Originally Issued On: 9/16/2025

New Order: 5-100 Water

5-102.13 Priority Level: Priority 2 CFP#: 31

MN Rule 4626.1005 Water from a public water system must be sampled and tested as required by chapter 4720, rules for public water supplies.

COMMENT: AT TIME OF INSPECTION NO ANNUAL WATER TESTS ARE BEING DONE ON PRIVATE WELL OR THE TESTS ARE SIMPLY UNAVAILABLE AS OWNERSHIP CHANGED AS OF LAST YEAR

Comply By: 10/31/2025 Originally Issued On: 9/16/2025

Food & Beverage General Comment

LOCATION IS USING DOMESTIC EQUIPMENT, AS A REMINDER ADULT CARE CENTERS CAN ONLY USE DOMESTIC

EQUIPMENT IF TCS FOODS ARE PREPARED ONLY FOR SAME DAY SERVICE

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 F1040251056 from 9/16/2025



Establishment Representative

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

Page: 1

Establishment Info

Brookside Assisted Living
Pine River
County/Group: Cass County

Inspection Info

Report Number: F1040251056
Inspection Type: Full
Date: 9/16/2025
Time: 10:00:41 AM

Food Temperature: Product/Item/Unit: FRIDGE 1, TATER TOT HOT DISH; Temperature Process: Cold-Holding

Location: Upright Cooler at 41 Degrees F.

Comment:

Violation Issued?: No

Equipment Temperature: Product/Item/Unit: RESIDENTIAL FRIDGE, AMBIENT TEMPERATURE; Temperature Process:

Cold-Holding

Location: Upright Cooler at 41 Degrees F.

Comment:

Violation Issued?: No

Equipment Temperature: Product/Item/Unit: FREEZER 1, AMBIENT TEMPERATURE; Temperature Process: Cold-

Holding

Location: Upright Freezer at 0 Degrees F.

Comment:

Violation Issued?: No

Equipment Temperature: Product/Item/Unit: STORAGE FREEZER 1 AND 2; Temperature Process: Cold-Holding

Location: Upright 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

Page: 1

Establishment Info

Brookside Assisted Living
Pine River
County/Group: Cass County

Inspection Info

Report Number: F1040251056
Inspection Type: Full
Date: 9/16/2025
Time: 10:00:41 AM

Sanitizing Equipment: Product: Hot Water; **Sanitizing Process:** Dish Machine

Location: Kitchen **Equal To** Degrees F.

Comment: AS THE DISH MACHINE TAKES OVER 4 HOURS TO SANITIZE, WAS UNABLE TO MEASURE

Violation Issued?: No

Sanitizing Chemical: Product: Quaternary Ammonia; **Sanitizing Process:** Spray Bottle

Location: Kitchen **Equal To** 400 PPM

Comment:

Violation Issued?: No