Electronically Delivered

April 28, 2026

Licensee
Farmstead Care of Moorhead
3200 28th Street South
Moorhead, MN 56560

RE: Project Number(s) SL31557016

Dear Licensee:

On April 14, 2026, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on January 29, 2026. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Jessie Chenze

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

CLN

Electronically Delivered

February 24, 2026

Licensee
Farmstead Care of Moorhead
3200 28th Street South
Moorhead, MN 56560

RE: Project Number(s) SL31557016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 29, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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

pursuant to this survey:

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00
St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,500.00**. 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,

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

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31557	A. BUILDING: _____ B. WING _____	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FARMSTEAD CARE OF MOORHEAD LP	3200 28TH STREET SOUTH MOORHEAD, MN 56560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL31557016-0 On January 26, 2026, through January 29, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 79 residents; 55 receiving services under the Assisted Living Facility with Dementia Care license. An immediate correction order was identified on January 26, 2026, issued for SL315572016-0, tag identification 1290. The licensee took action on January 26, 2026, to mitigate the risk; however, the scope and level remains at level 3/Widespread (I).	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the clinical nurse supervisor (CNS) developed and implemented a staffing plan to determine staffing levels to meet the needs of all residents, which included reviewing the staffing plan at least twice per year. In addition, the licensee failed to ensure the daily staffing schedule was posted in a central location as required. This had the potential to affect all residents, staff, and visitors.	0 470		

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0 470	Continued From page 2 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: The licensee held an assisted living with dementia care license and was licensed for a capacity of 137 residents, with a current census of 79 residents. During the entrance conference on January 26, 2026, at 9:32 a.m., licensed assisted living director (LALD)-A stated LALD-A and CNS-L had developed a staffing plan and reviewed it "quite often". LALD-A and licensed practical nurse (LPN)-C stated the licensee's regular staffing schedule was the following: -three to four unlicensed personnel (ULPs) worked 7:00 a.m. until 3:30 p.m.; -four to five ULPs worked 7:00 a.m. until 7:30 p.m.; -three to four ULPs worked 3:00 p.m. until 11:30 p.m.; and -five to six ULPs worked 7:00 p.m. until 7:30 a.m. On January 26, 2026, from 10:11 a.m. through 11:31 a.m., the surveyor toured the campus consisting of two buildings (assisted living and Villa), which housed residents, with LALD-A. The surveyor did not observe the daily staffing schedule posted in either building.	0 470		

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0 470	Continued From page 3 The licensee's undated Staffing Plan indicated the average acuity levels for residents in AL North, AC North, AL South, and AC South were all "MID". The average acuity level for residents at Villa was "LOW." The staffing plan indicated the following: -six ULPs worked 12-hour day shifts; -five ULPs worked eight-hour day shifts; -one and a half registered nurses (RNs) worked 8-hour day shifts; -two LPNs worked eight-hour day shifts; -one RN worked eight hours on call evening shift; -five ULPs worked eight-hour evening shifts; -one RN worked 12 hours on call night shift; -five ULPs worked 12-hour night shifts; and -one ULP worked eight-hour night shift. The licensee's staffing plan lacked evidence a metric was used to determine staffing needs and being reviewed at least twice per year. In addition, the licensee lacked evidence a daily staffing schedule was posted. On January 28, 2026, at 11:27 a.m., LALD-A stated the licensee had set up the staffing plan about a year ago with the nursing consultant and LALD-A thought the staffing plan needed to be reviewed once a year. LALD-A further stated the licensee discussed the staffing plan with census changes, however, the census had not changed much in the last year. On January 28, 2026, at 11:29 a.m., LPN-C stated the licensee posted the staff scheduled in the staff break room. LALD-A further stated the front desk has a copy of the schedule, however, it was not posted. LALD-A stated the licensee was not aware the staff schedule needed to be posted in a central area.	0 470		

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0 470	Continued From page 4 The licensee's undated Staffing Plan for Direct Care Employees policy dated June 1, 2025, indicated the staffing plan will provide qualified direct-care staff sufficient to meet the residents' needs 24-hours a day, 7 days a week and will be adequate to address: -each resident's needs as identified in the service plan and assisted living contract; -each resident's acuity level as determined by the most recent assessment or individualized review; -ability to meet the residents' scheduled and reasonably unforeseeable unscheduled needs given the physical layout of the facility premises; -the staff plan will indicate if the assisted living has a secured dementia unit; and -staff competency and training. In addition, the policy indicated the staffing plan will be evaluated and reviewed as needed at a minimum of two times per year. The daily work schedule will be posted at the beginning of each shift. The daily work schedule will be posted in a central location in each building accessible to staff, residents, and the public. The licensee's Required Postings policy dated June 1, 2025, indicated the staffing schedule for the shift would be posted. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0180, Subp. 3, effective October 2022, the CNS must develop and implement a written staffing plan that provides an adequate number of qualified direct-care staff to meet the residents' needs 24 hours a day, seven days a week. When developing a direct-care staffing plan, the CNS must ensure that staffing levels are adequate to address the following: (A) each resident's needs, as identified in the resident's service plan and assisted living	0 470		

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0 470	Continued From page 5 contract; (B) each resident's acuity level, as determined by the most recent assessment or individualized review; (C) the ability of staff to timely met the residents' scheduled and reasonably foreseeable unscheduled needs given the physical layout of the facility premises; (D) whether the facility has a secured dementia care unit; and (E) staff experience, training, and competency. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0180, Subp. 4., A, effective October 2022, the CNS must develop a 24-hour daily staffing schedule. The schedule must: (1) include direct-care staff work schedules for each direct-care staff member showing all shifts, including days and hours worked; and (2) identify the direct-care staff member's resident assignments or work location. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0180, Subp. 4, B, effective October 2022, the daily work schedule in item A must be posted, after redacting direct-care staff members' resident assignments, at the beginning of each work shift in a central location in each building of a facility or campus, accessible to staff, residents, volunteers, and the public. The facility shall not disclose any information that is protected by law from public disclosure. No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	0 470		

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0 480	Continued From page 6	0 480		
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 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;	0 480		

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0 480	Continued From page 7 (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: 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 January 26, 2026, for the specific Minnesota Food Code violations. The Inspection	0 480		

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0 480	Continued From page 8 Report was provided to the licensee within 95 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services (a) All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not require any resident to include and pay for meals as a part of their assisted living contract. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that will cause only minimal impact on	0 485		

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0 485	Continued From page 9 the resident and does not affect health or safety) 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 January 26, 2026, at 9:15 a.m., licensed assisted living director (LALD)-A stated the licensee was familiar with current minimum assisted living requirements. On January 26, 2026, at 9:20 a.m., licensed practical nurse (LPN)-C stated the licensee provided an assisted living contract with a meal addendum for residents to elect to receive the meal plan or had the option to opt out of the meal plan. On page six of the undated Assisted Living Contract, Section 1: Housing Related Services Included in the Monthly Rent indicated availability of three (3) nutritious meals per day, with options for a specialized diet on a case-by-case basis. The licensee's undated Meal/Food Plan Addendum indicated the resident could be provided three meals per day with the food plan or could select no meal plan through the licensee. Resident assisted living contracts with meal addendums lacked an option for residents to opt out of payment for one or two meals residents would not want. On January 28, 2026, at 12:04 p.m., LALD-A stated the licensee only had options for residents to receive and pay for three meals per day or opt	0 485		

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0 485	Continued From page 10 out of all meals. LALD-A further stated residents can refuse to eat three meals per day, however, residents would still be charged for the three meals per day meal plan. The Minnesota Department of Health Assisted Living Resources and Frequently Asked Questions (FAQs) website, last updated October 13, 2025, indicated the provider cannot have a blanket "one size fits all" meal charge. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post required content in common areas to include posting the 911 emergency number and the reporting number	0 640		

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	31557	A. BUILDING: _____ B. WING _____	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FARMSTEAD CARE OF MOORHEAD LP	3200 28TH STREET SOUTH MOORHEAD, MN 56560

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0 640	Continued From page 11 for the Minnesota Adult Abuse Reporting Center (MAARC) to report suspected maltreatment of a vulnerable adult under section 626.557 at the assisted living. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 January 26, 2026, at 9:15 a.m., licensed assisted living director (LALD)-A stated the licensee was familiar with current minimum assisted living requirements. On January 26, 2026, from 10:11 a.m. through 11:31 a.m., the surveyor toured the campus consisting of two buildings (assisted living and Villa), which housed residents, with LALD-A. The surveyor did not observe any postings with the 911 emergency number or the number for MAARC at Villa. LALD-A stated LALD-A had thought all required postings were posted at Villa. On January 28, 2026, at 11:39 a.m., LALD-A stated LALD-A was aware 911 and MAARC numbers were supposed to be posted at the assisted living facility. The licensee's Required Postings policy dated June 1, 2025, indicated the phone numbers for	0 640		

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0 640	Continued From page 12 911 and MAARC would be posted. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
0 650 SS=F	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 infomation: (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 observation, interview, and record review, the licensee failed to ensure employee records contained the required content for two of	0 650		

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0 650	Continued From page 13 two employees (unlicensed personnel (ULP)-I, ULP-J). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on January 26, 2026, at 9:29 a.m., licensed assisted living director (LALD)-A and licensed practical nurse (LPN)-C stated the licensee was aware of the required contents of the employee records. ULP-I ULP-I was hired on June 18, 2024, to provide direct assisted living services to residents at the facility. On January 27, 2026, at 7:13 a.m., ULP-I stated ULP-I completed training and competency testing with a registered nurse (RN) upon hire. On January 27, 2026, at 7:42 a.m., the surveyor observed ULP-I administer R3's scheduled morning medication. ULP-J ULP-J was hired on January 2, 2025, to provide direct assisted living services to residents at the facility. On January 27, 2026, at 7:28 a.m., ULP-J stated	0 650		

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0 650	Continued From page 14 ULP-J was trained and competency tested by the licensee's RN upon hire. On January 27, 2026, at 10:13 a.m., the surveyor observed ULP-J administer R6's scheduled morning medication. During the observation the surveyor observed R6 wearing a right-hand brace and left leg ankle-foot orthoses (AFO). In addition, the surveyor observed R6's therapy vest (inflatable vest and air-pulse generator to vibrate the chest, loosening and thinning mucus in the lungs to improve breathing) ULP-I and ULP-J's employee records lacked documentation of training and competency testing for vest therapy, AFOs, resident's unplanned time away medication procedures, and condom catheters. On January 29, 2026, at 11:31 a.m., RN-B stated the licensee had changed the process on how ULPs were trained and competency tested upon hire. RN-B stated RN-B had provided refresher courses for all ULPs when RN-B started with the licensee on April 3, 2025. RN-B further stated ULPs were trained on AFO's, condom catheters, and unplanned time away upon hire. RN-B stated RN-B would have to review the employee records and provide the surveyor with the training and competency documentation, however, the surveyor did not receive any additional documentation for the training and competency areas noted above. On January 29, 2026, at 11:58 a.m., LPN-C stated the licensee had provided the surveyor with all documentation from the employee records the licensee could locate. The licensee's Employee Records policy dated	0 650		

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0 650	Continued From page 15 June 1, 2025, indicated the personnel file for each person will include record of all required training for ULP and competency evaluations. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0190, Subp. 6, effective October 2022, the licensee must maintain a record of staff training and competency required under this part and Minnesota Statutes, chapter 144G, that documents the following information for each competency evaluation, training, retraining, and orientation topic: (1) facility name, location, and license number; (2) name of the training topic or training program, and the training methodology, such as classroom style, web-based training, video, or one-to-one training; (3) date of the training and competency evaluation, and the total amount of time of the training and competency evaluation; (4) name and title of the instructor and the instructor's signature, and the name and title of the competency evaluator, if different from the instructor, and the evaluator's signature with a statement attesting that the employee successfully completed the training and competency evaluation; and (5) name and title of the staff person completing the training, and the staff person's signature with statement attesting that the staff person successfully completed the training as described in the training documentation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		

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0 775	Continued From page 16	0 775		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated January 26, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
01290 SS=I	144G.60 Subdivision 1 Background studies required	01290		

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01290	Continued From page 17 (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 clearance letter for two of seven employees (dining staff (DS)-F, DS-G). This had the potential to affect all residents living within the facility. 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: This resulted in an immediate correction order on January 26, 2026.	01290		

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01290	Continued From page 18 During the entrance conference on January 26, 2026, at 9:29 a.m., licensed assisted living director (LALD)-A and licensed practical nurse (LPN)-C stated the licensee was aware of required contents in an employee record. DS-F DS-F was hired on December 7, 2022, to assist residents with dining needs. DS-F's Clock In/Out History dated January 1, 2026, through January 26, 2026, respectively, indicated DS-F had worked over 40 hours for the licensee. DS-G DS-G was hired on August 26, 2025, to assist residents with dining needs. DS-G's Clock In/Out History dated January 1, 2026, through January 26, 2026, respectively, indicated DS-G had worked over 34 hours for the licensee. DS-F and DS-G's employee records lacked a current cleared background study listed on the licensee's NETStudy 2.0 Roster. On January 26, 2026, at 1:19 p.m., the surveyor reviewed the licensee's NETStudy 2. 0 Roster with human resources (HR)-H. HR-H stated HR-H was responsible for completing all employee background studies upon employment with the licensee. HR-H searched DS-F's name, date of birth, and social security number on NETStudy 2.0 website, however, the results indicated no matching individuals found. HR-H stated DS-F worked part time as a baker during overnight hours for the licensee. In addition,	01290		

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01290	Continued From page 19 HR-H stated the licensee did not require any employee under the age of 18 to complete a NETStudy 2.0 background study. On January 26, 2026, at 1:51 p.m., LALD-A stated the licensee's nurse consultant had advised the licensee a background study was not required for employees under the age of 18. The licensee's Background Study policy dated January 11, 2023, indicated all onboarding staff are required to complete a background study and followed by fingerprinting as applicable and will enter information into NETStudy 2.0 background portal within five days of general orientation. 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 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	01290		

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01290	Continued From page 20 study notices for supervision status and other background study determination information. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and	01470		

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01470	Continued From page 21 (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure orientation to assisted living statutes included all the required content for one of three employees (registered nurse (RN)-B). 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	01470		

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01470	Continued From page 22 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 January 26, 2026, at 9:29 a.m., licensed assisted living director (LALD)-A and licensed practical nurse (LPN)-C stated the licensee was aware of the required contents of the employee records. RN-B was hired on April 3, 2025, to provide direct care, supervision of staff, and staff training for the licensee. RN-B's employee record contained Staff Training transcript dated February 1, 2025, however, RN-B's employee record lacked the following required orientation: -an overview of 144G statutes; and -handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints. On January 28, 2026, at 11:44 a.m., LPN-C stated the licensee had recently started using Residex (electronic medical record system platform) for employee orientation. On January 29, 2026, at 11:18 a.m., RN-B stated RN-B received orientation upon hire and would provide the surveyor with training topics noted above, however, the surveyor did not receive any additional documentation. On January 29, 2026, at 11:58 a.m., LPN-C	01470		

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01470	Continued From page 23 stated the licensee had provided the surveyor with all documentation from the employee records the licensee could locate. The licensee's Orientation to Assisted Living- All Staff policy dated June 1, 2025, indicated newly hired staff will receive orientation and training on topics including an overview of Minnesota's assisted living law and handling resident complaints. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01530 SS=D	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	01530		

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01530	Continued From page 24 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 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 interview and record review, the licensee failed to ensure orientation to assisted living statutes included all the required content for one of two employees (registered nurse (RN)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	01530		

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	31557	A. BUILDING: _____ B. WING _____	01/29/2026

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01530	Continued From page 25 During the entrance conference on January 26, 2026, at 9:29 a.m., licensed assisted living director (LALD)-A and licensed practical nurse (LPN)-C stated the licensee was aware of required contents of an employee record. RN-E was hired May 14, 2025, through a contracted agency, to provide on-call RN access for staff and residents at the facility. RN-E's Educare (online training platform) transcript indicated RN-E had completed six hours of dementia training. RN-E's employee record lacked eight hours of initial dementia training within 120 hours of employment start date. On January 28, 2026, at 11:55 a.m., LPN-C stated RN-E's transcript indicated RN-E had completed six hours of dementia training assumed RN-E had provided more than 120 hours of on-call for the licensee. LALD-A further stated LALD-A had thought the contract agency ensured all on-call staff met the requirement of eight hours of initial dementia training. On January 30, 2026, at 12:24 p.m., LPN-C emailed (electronic mail) the surveyor an updated Educare transcript for RN-E, which indicated RN-E had completed the required eight hours of dementia training, however, two hours of dementia training were not completed until January 29, 2026 (three days after survey entrance). The licensee's Dementia Training Policy dated June 1, 2025, indicated supervisors of direct-care staff will complete a minimum of 8 (eight) hours of initial training on dementia care topics.	01530		

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01530	Continued From page 26 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to	01730		

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01730	Continued From page 27 documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the registered nurse (RN) failed to develop and maintain a current individualized medication management plan for each resident to include all required content for one of four residents (R6). 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 January 26, 2026, at 9:19 a.m., licensed practical nurse (LPN)-C stated the licensee provided medication management services to residents at the facility.	01730		

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01730	Continued From page 28 R6's diagnoses included Bell's Palsy (weakness or paralysis of muscles on one side of the face), quadriplegia (partial or total loss of sensory and motor function in all four extremities), and chronic pain syndrome. R6's Addendum to Contract- Waiver- MN (Minnesota) (service plan) dated November 20, 2025, indicated R6 received medication administration 14 times per day. R6's prescriber orders dated January 5, 2026, included the following orders: -barrier cream (skin protectant) apply topically twice daily to red areas -Eucerin Cream (for dry skin) apply topically twice daily -Rowe Casa Muscle and Joint Pain cream (for muscle and joint pain) apply topical twice per day to left upper back. Kept in R6's room next to R6's bed. R6's Med (medication) Admin (administration) Summary- Actual- Month dated December 2025, and January 2026, respectively indicated R6's medications received included the following: -barrier cream apply topically twice daily to red areas -Eucerin Cream apply topically to skin twice daily -Rowe Casa Muscle and Joint Pain cream apply a marble size amount to left upper back at area of pain twice daily. Kept in R6's room next to R6's bed. On January 27, 2026, at 10:13 a.m., the surveyor observed unlicensed personnel (ULP)-J complete scheduled morning medication administration for R6. ULP-J stated R6's topical medication creams were stored in R6's apartment.	01730		

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01730	Continued From page 29 R6's Individualized Medication Management Plan dated November 20, 2025, indicated R6's medications were stored in the secured medication cart. R6's individualized medication management plan did not match current medication storage for R6. On January 29, 2026, at 11:53 a.m., LPN-C and RN-B stated the licensee was not aware R6's topical medications were stored in R6's room. RN-B further stated R6 needed to be assessed for appropriate storage of topical medications and R6's individual medication management plan needed to be reviewed to reflect current storage of topical medication. The licensee's Individualized Medication, Treatment, and Therapy Management Plans policy dated June 1, 2025, indicated the RN will develop a medication management plan, which included a description of medication storage based upon the resident's needs, preferences, risk of diversion, and in keeping with the manufacturer's instructions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation	01760		

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01760	Continued From page 30 must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medication was administered per prescriber orders for one of three employees (unlicensed personnel (ULP)-I). 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 January 26, 2026, at 9:19 a.m., licensed practical nurse (LPN)-C stated the licensee provided medication management services to residents at the facility. ULP-I's employee record indicated ULP-I completed insulin administration training and was competency tested on July 17, 2024. R4's diagnoses included diabetes and hypertension (HTN- high blood pressure).	01760		

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01760	Continued From page 31 R4's Addendum to Contract- Private- MN (Minnesota) (service plan) dated October 3, 2025, indicated R4's services included medication administration seven times per day. R4's prescriber orders dated January 23, 2026, included orders for Novolog 100 units/milliliter (mL) inject 10 units subcutaneously (fatty layer between skin and muscle) three times per day with meals. R4's Med (medication) Admin (administration) Summary- Actual- Month dated January 2026, indicated Novolog inject 10 units under the skin three times daily. On January 27, 2026, at 9:20 a.m., the surveyor observed ULP-I compare R4's Novolog insulin pen to R4's electronic medication administration record (EMAR). ULP-I entered R4's apartment, applied the needle to R4's Novolog insulin pen, dialed the Novolog insulin pen to 10 units, and injected the Novolog insulin into R4's upper thigh. The surveyor did not observe ULP-I prime R4's Novolog insulin pen with two (2) units of insulin and discard prior to dialing up 10 units of Novolog to ensure the needle contained insulin and allowed R4 to get the full 10 units of Novolog insulin. Immediately following the observation, ULP-I stated ULP-I was not trained to prime insulin pens with two units and discard prior to administration of insulin. On January 29, 2026, at 11:20 a.m., registered nurse (RN)-B stated ULPs were trained to prime insulin pens with two units of insulin and discard prior to dialing the insulin pen to the prescribed insulin dose.	01760		

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01760	Continued From page 32 The manufacturer's instructions for Novolog dated February 2015, indicated after applying the needle to the insulin pen, turn the dose selector to select 2 (two) units and discard. A drop of insulin should appear at the needle tip. The licensee's Administration of Medication, Treatment, and Therapy by ULP policy dated June 1, 2025, indicated the RN may delegate administration of medications to ULPs if the RN has instructed the ULP in the proper methods to administer the medications and the ULP demonstrated the ability to competently follow the procedures. The licensee's Medication Administration and Set Up policy dated July 16, 2024, indicated caregivers (ULPs) will also document any reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01890 SS=D	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.	01890		

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01890	Continued From page 33 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 one of four residents (R4). 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 January 26, 2026, at 9:19 a.m., licensed practical nurse (LPN)-C stated the licensee provided medication management services to residents at the facility. On January 27, 2026, at 9:20 a.m., the surveyor observed unlicensed personnel (ULP)-I complete scheduled morning medication administration for R4, which included the administration of Novolog 100 units per milliliter (mL) insulin pen. R4's Novolog insulin pen was not labeled with an open date or expiration date. ULP-I stated R4's Novolog insulin pen was not labeled with an open date or expiration date. On January 28, 2026, at 10:04 a.m., ULP-I stated medication carts were audited weekly by care coordinators (ULPs) to place labels on time	01890		

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01890	Continued From page 34 sensitive medications and monitor for expired medications. On January 28, 2026, at 11:50 a.m., LPN-C stated care coordinators (ULPs) put a sticker labeled with the open date and expiration date on the time sensitive medications when the medications were checked into the medication cart. On January 29, 2026, at 11:19 a.m., registered nurse (RN)-B stated time sensitive medications, including insulin pens, were supposed to be labeled with the open date and expiration date of the medication. RN-B further stated ULPs were trained regarding labeling time-sensitive medications during the medication class upon hire. The manufacturer's instructions for use of Novolog dated February 2015, indicated to discard the Novolog insulin pen 28 days after opening, even if the insulin pen still contains insulin. The licensee's Storage of Medications policy dated June 1, 2025, indicated until the medication is set up for immediate or later administration by a nurse, a legend drug must be kept in its original container bearing the original prescription label with legible information including expiration date of time-dated drug. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

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01910	Continued From page 35	01910		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record all required content for disposition of the medications for one of one resident (R1) upon discharge. 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	01910		

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01910	Continued From page 36 situation has occurred only occasionally). The findings include: During the entrance conference on January 26, 2026, at 9:19 a.m., licensed practical nurse (LPN)-C stated the licensee provided medication management services to residents at the facility. The licensee's Discharged Resident/Client Roster dated January 1, 2025, through January 26, 2026, indicated R1 was admitted to the facility on September 12, 2025, and discharged on December 4, 2025. R1's diagnoses included hypertension (HTN- high blood pressure), anxiety, and upper airway cough syndrome. R1's Addendum to Contract- Waiver- MN (Minnesota) (service plan) dated October 1, 2025, indicated R1 received medication administration five times per day. R1's Med (medication) Admin (administration) Summary- Actual- Month dated November 2025, and December 2025, respectively, indicated R1 received or was prescribed the following medications: -clonazepam (antianxiety) 0.5 milligrams (mg) three times daily -famotidine (antacid) 20 mg daily -Xyzal (antihistamine) 5 mg daily -ibuprofen (for pain) 600 mg daily -gabapentin (for pain or anxiety) 200 mg daily -lorazepam (antianxiety) 1 mg twice daily -cetirizine (for allergies) 10 mg daily -acetaminophen (for pain) 1,000 mg daily -loratadine (for allergies) 10 mg twice daily as needed	01910		

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01910	Continued From page 37 -ondansetron (for nausea) 8 mg every eight hours as needed -albuterol HFA (for wheezing, shortness of breath, coughing) two puffs every four hours as needed R1's prescriber orders dated September 12, 2025, included the above noted medications. R1's Resident Discharge Summary dated December 4, 2025, indicated R1 moved to a skilled nursing facility and R1's medications were given to resident/POA (power of attorney). R1's Current Medications at Discharge (medication disposition) dated December 3, 2025, listed the above noted medications, however, lacked albuterol HFA's prescription number and quantity sent with R1. On January 28, 2026, at 11:59 a.m., LPN-C stated medication disposition documentation included prescription numbers and quantity given or destroyed. LPN-C further stated LPN-C was not sure why R1's medication disposition lacked albuterol HFA's prescription number and quantity. On January 29, 2026, at 11:32 a.m., registered nurse (RN)-B stated medication disposition documentation requirements included prescription numbers and the medication amount provided to the resident or destroyed. The licensee's Disposal of Medications policy dated June 1, 2025, indicated when medication management services have been terminated the medications will be given to the resident or the resident's representative. Staff will document in the resident's record the name of the person to whom the medications were given, the time and date, the name of each medication and the	01910		

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01910	Continued From page 38 amount of medication remaining. The policy did not address the medication prescription number. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) specified, in writing, specific instructions for one of four residents (R4) receiving treatment management services.	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31557	A. BUILDING: _____ B. WING _____	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FARMSTEAD CARE OF MOORHEAD LP	3200 28TH STREET SOUTH MOORHEAD, MN 56560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01950	Continued From page 39 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 January 26, 2026, at 9:28 a.m., licensed practical nurse (LPN)-C stated the licensee provided treatment and therapy services to residents. R4's diagnoses included diabetes and HTN. R4's Addendum to Contract- Private- MN (Minnesota) (service plan) dated October 3, 2025, indicated R4's services included dressing, including shoulder immobilizer sling, daily. R4's prescriber orders dated January 23, 2026, included orders for brace (shoulder immobilizer sling). R4's Service Recap Summary- Month dated January 2026, indicated brace (shoulder immobilizer sling) three times daily. On January 27, 2026, at 9:20 a.m., the surveyor observed unlicensed personnel (ULP)-I administer R4's scheduled morning medication. During the observation, the surveyor observed R4 wearing the shoulder immobilizer sling on R4's left arm. R4's record lacked specific instructions for ULPs	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31557	A. BUILDING: _____ B. WING _____	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FARMSTEAD CARE OF MOORHEAD LP	3200 28TH STREET SOUTH MOORHEAD, MN 56560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01950	Continued From page 40 to notify the RN when a problem arises regarding R4's shoulder immobilizer sling. On January 29, 2026, at 9:34 a.m., ULP-K stated ULPs assist with putting on R4's shoulder immobilizer sling. On January 29, 2026, at 11:39 a.m., RN-B stated any treatment a resident receives from a ULP should have specifics listed when to notify a registered nurse. RN-B further stated R4's should immobilizer sling was listed as a service instead of a treatment in the R4's electronic medical record and lacked specific instructions for ULPs. The licensee's Individualized Medication, Treatment, and Therapy Management Plans policy dated June 1, 2025, indicated the treatment and therapy management plans will include procedures for notifying an RN or appropriate licensed health professional when a problem arises with treatments and/or therapy services. No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	01950		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31557	A. BUILDING: _____ B. WING _____	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FARMSTEAD CARE OF MOORHEAD LP	3200 28TH STREET SOUTH MOORHEAD, MN 56560

(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
02110	Continued From page 41 shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement all required policies and procedures related to dementia care. In addition, the licensee failed to ensure the required dementia care policies and procedures were provided to each resident and/or the resident's legal and designated representatives. This practice resulted in a level two violation (a	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31557	A. BUILDING: _____ B. WING _____	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FARMSTEAD CARE OF MOORHEAD LP	3200 28TH STREET SOUTH MOORHEAD, MN 56560

(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
02110	Continued From page 42 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 January 26, 2026, at 9:15 a.m., licensed assisted living director (LALD)-A stated the licensee was familiar with current minimum assisted living requirements. The facility held an Assisted Living with Dementia Care license effective September 1, 2025, through August 31, 2026. The licensee's (licensee name) Dementia Program Disclosure dated May 28, 2025, provided to each resident and/or resident's legal and designated representatives upon move in, did not address the following required policies and procedures: -evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; -wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; -medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; -limiting the use of public address and intercom systems for emergencies and evacuation drills	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31557	A. BUILDING: _____ B. WING _____	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FARMSTEAD CARE OF MOORHEAD LP	3200 28TH STREET SOUTH MOORHEAD, MN 56560

(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
02110	Continued From page 43 only; -transportation coordination and assistance to and from outside medical appointments; and -safekeeping of residents' possessions. On January 28, 2026, at 12:03 p.m., LALD-A stated LALD-A would have to look for additional dementia policies the licensee provided to residents upon move in, however, no additional dementia policies were provided to the surveyor. On January 29, 2026, at 12:04 p.m., licensed practical nurse (LPN)-C stated the licensee had not been able to locate policies addressing the topics noted above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		
02350 SS=D	144G.91 Subd. 7 Courteous treatment Residents have the right to be treated with courtesy and respect, and to have the resident's property treated with respect This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure residents were treated with dignity and respect in relation to privacy of health provisions of care for one of two residents (R7). 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	02350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31557	A. BUILDING: _____ B. WING _____	01/29/2026

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02350	Continued From page 44 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 January 26, 2026, at 9:15 a.m., licensed assisted living director (LALD)-A stated the licensee was familiar with current minimum assisted living requirements. R7's diagnoses included dementia with agitation, fracture of right femur, and retention of urine. R7's Addendum to Contract- Private- MN (Minnesota) (service plan) dated December 29, 2025, indicated R7's services included medication administration, catheter care, empty catheter (urinary collection bag), position/repositioning, and assistance with bathing, grooming, dressing, transfers, laundry, and housekeeping. R7's 90-day Assessment dated December 17, 2025, indicated R7 had an indwelling Foley catheter. On January 27, 2026, at 8:33 a.m., the surveyor observed R7 sitting in R7's Broda (specialized) wheelchair located in the shared resident dining room with five other residents present. The surveyor observed R7's urinary collection bag, approximately 1/8 full of urine, hanging from the side of R7's Broda wheelchair. Unlicensed personnel (ULP)-J stated R7's urinary catheter bag was usually covered with a dignity bag.	02350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31557	A. BUILDING: _____ B. WING _____	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FARMSTEAD CARE OF MOORHEAD LP	3200 28TH STREET SOUTH MOORHEAD, MN 56560

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02350	Continued From page 45 On January 28, 2026, at 11:53 a.m., licensed practical nurse (LPN)-C stated resident catheter bags were supposed to be covered with a dignity bag. On January 29, 2026, at 11:22 a.m., registered nurse (RN)-B stated the licensee expected staff to ensure urinary catheter bags were covered while in public areas to respect the dignity of the resident and provide person-centered care. RN-B further stated the licensee had discussed options with residents and/or resident's designated representative to switch to a catheter leg bag (placed on the resident's leg under clothing) during the day to prevent the urinary collection bag from potentially being exposed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02350		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the required notice to visitors was posted at the main entry way of the establishment to display statutory	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31557	A. BUILDING: _____ B. WING _____	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FARMSTEAD CARE OF MOORHEAD LP	3200 28TH STREET SOUTH MOORHEAD, MN 56560

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03090	Continued From page 46 language to disclose electronic monitoring activity, potentially affecting all residents, staff, and visitors of the licensee. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) 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 January 26, 2026, at 9:15 a.m., licensed assisted living director (LALD)-A stated the licensee was familiar with current minimum assisted living requirements. On January 26, 2026, from 10:11 a.m. through 11:31 a.m., the surveyor toured the campus consisting of two buildings (assisted living and Villa), which housed residents, with LALD-A. The Villa lacked any posting regarding electronic monitoring. LALD-A stated LALD-A had thought all required postings were posted at Villa. On January 28, 2026, at 12:37 p.m., licensed practical nurse (LPN)-C stated Villa lacked the required electronic monitoring posting. The licensee's Required Postings policy dated June 1, 2025, indicated Electronic Monitoring [sic] would be posted as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31557	A. BUILDING: _____ B. WING _____	01/29/2026

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

Food & Beverage Inspection Report

Establishment Info

FARMSTEAD CARE OF MOORHEAD LP
3200 28th Street South
Moorhead, MN 56560
Clay County
Parcel:

Phone:

License Info

License: HFID 31557

Risk:
License:
Expires on:
CFPM: Jennifer Smith
CFPM #: 115697; Exp: 03/27/2026

Inspection Info

Report Number: F1049261015
Inspection Type: Full - Single
Date: 1/26/2026 Time: 11:15 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 2
Total Priority 3 Orders: 2
Delivery: Emailed

New Order: 3-300C Protection from Contamination: equipment/utensils, consumers
3-304.14B *Priority Level: Priority 3 CFP#: 41*
MN Rule 4626.0285B Wiping cloths used for wiping counters and other equipment surfaces must be held in an approved sanitizing solution and laundered daily.
COMMENT: THE MAIN KITCHEN 2 PREP AREA WIPING CLOTH BUCKET TESTED AT 100 PPM QUAT. PIC REFRESHED THE SANITIZER. THE WIPING CLOTH BUCKET THEN RETESTED AT 200 PPM QUAT.
Comply By: Complied On Site Originally Issued On: 1/26/2026

New Order: 4-300 Equipment Numbers and Capacities
4-302.13B *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.
COMMENT: PIC INSTRUCTED TO OBTAIN A DISH MACHINE THERMOMETER FOR BOTH MAIN KITCHENS TO REGULARLY TEST THE UTENSIL SURFACE TEMPERATURE.
Comply By: 1/26/2026 Originally Issued On: 1/26/2026

New Order: 4-600 Cleaning Equipment and Utensils
4-602.11E *Priority Level: Priority 3 CFP#: 16*
MN Rule 4626.0845E Clean surfaces contacting food that is not TCS: 1. at any time when contamination may have occurred; 2. at least once every 24 hours for iced tea dispensers and consumer self-service utensils; 3. before restocking consumer self-service equipment and utensils such as condiment dispensers, and display containers; 4. at a frequency specified by the manufacturer or at a frequency necessary to preclude accumulation of soil or mold for ice bins, beverage dispensing nozzles, enclosed components of ice makers, cooking oil storage tanks and distribution lines, beverage and syrup dispensing lines or tubes, coffee bean grinders, and water vending equipment.
COMMENT: IN THE STORAGE ROOM BY MAIN KITCHEN 1, ON THE BOTTOM OF THE INTERIOR ICE MACHINE DISPENSING COMPONENT, THERE WAS BUILD UP OF BLACK DEBRIS. PIC INSTRUCTED TO CLEAN THE ICE DISPENSING COMPONENT ACCORDINGLY.
Comply By: 1/26/2026 Originally Issued On: 1/26/2026

New Order: 6-300 Physical Facility Numbers and Capacities
6-301.11 *Priority Level: Priority 2 CFP#: 10*
MN Rule 4626.1440 Provide an adequate supply of hand soap at each handwashing sink or group of 2 adjacent handwashing sinks.
COMMENT: THE SOUTH EVENTS AL CARE SERVING KITCHEN LACKED HAND SOAP. PIC REFILLED THE HAND SOAP DURING THE INSPECTION.
Comply By: Complied On Site Originally Issued On: 1/26/2026

Food & Beverage General Comment

INSPECTOR MET WITH MDH NURSE EVALUATOR AND ESTABLISHMENT REPRESENTATIVE.

ESTABLISHMENT HAS TWO ANSI CERTIFIED KITCHENS. THE MAIN KITCHEN 1 PROVIDES FOOD FOR ALL OF THE SERVING KITCHENS THROUGHOUT THE ESTABLISHMENT. MAIN KITCHEN 2 SERVES FOOD DIRECTLY TO THE RESIDENTS.

SOUTH SIDE AL SERVING KITCHEN HAS VINYL PLANKING FLOOR, SMOOTH COUNTERS, AND PAINTED WALLS.

SOUTH EVENTS AL CARE AND NORTH AL CARE SERVING KITCHENS BOTH HAVE DROP CEILING TILES, QUARRY FLOOR TILES, FRP WALLS, AND WOOD CABINETS.

NORTH EVENTS AL CARE SERVING KITCHEN HAS PAINTED WALLS, VINYL PLANKING FLOOR, DROP CEILING TILES, WOOD CABINETS, AND SMOOTH COUNTERS.

BOTH MAIN KITCHEN DISH MACHINES TESTED ABOVE 160 DEGREES F UTENSIL SURFACE TEMPERATURE, INDICATING THAT DISHES AND UTENSILS ARE BEING PROPERLY SANITIZED.

Things to Remember:

1. The Certified Food Manager should be routinely conducting self inspections to ensure that employees are following proper food handling practices.

2. Educate employees on the importance of reporting to management any illness they have or have had recently. Management should exclude any workers ill with vomiting or diarrhea from handling food, and they should keep an up to date employee illness log.

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

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

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

I acknowledge receipt of the Fergus Falls District Office inspection report number F1049261015 from 1/26/2026

Stephanie Reynolds

Establishment Representative

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

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

Temperature Observations/Recordings

Establishment Info

FARMSTEAD CARE OF MOORHEAD LP
Moorhead
County/Group: Clay County

Inspection Info

Report Number: F1049261015
Inspection Type: Full
Date: 1/26/2026
Time: 11:15 AM

Food Temperature: Product/Item/Unit: Onion**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 39.9 Degrees F.
Comment: Main Kitchen 1
Violation Issued?: No

Food Temperature: Product/Item/Unit: Mixed Veggies**; Temperature Process:** Cold-Holding
Location: Upright Cooler 2 at 40.5 Degrees F.
Comment: Main Kitchen 1
Violation Issued?: No

Food Temperature: Product/Item/Unit: Butter**; Temperature Process:** Cold-Holding
Location: Prep Cooler at 40 Degrees F.
Comment: Main Kitchen 1
Violation Issued?: No

Food Temperature: Product/Item/Unit: Soup Dumplings**; Temperature Process:** Hot-Holding
Location: Steam Table at 183 Degrees F.
Comment: Main Kitchen 1
Violation Issued?: No

Food Temperature: Product/Item/Unit: Soup Dumplings**; Temperature Process:** Hot-Holding
Location: Steam Table 2 at 172 Degrees F.
Comment: Main Kitchen 1
Violation Issued?: No

Food Temperature: Product/Item/Unit: Apple Juice**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 40 Degrees F.
Comment: South Side AL Serving Kitchen
Violation Issued?: No

Food Temperature: Product/Item/Unit: Prune Juice**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 41 Degrees F.
Comment: South Events AL Care Serving Kitchen
Violation Issued?: No

Food Temperature: Product/Item/Unit: Prune Juice**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 41 Degrees F.
Comment: North AL Care Serving Kitchen
Violation Issued?: No

Food Temperature: Product/Item/Unit: Cranberry Juice**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 40.9 Degrees F.
Comment: North Events Care Serving Kitchen
Violation Issued?: No

Food Temperature: **Product/Item/Unit:** Beef Soup**; Temperature Process:** Hot-Holding
Location: Steam Table at 152.5 Degrees F.
Comment: Main Kitchen 2
Violation Issued?: No

Food Temperature: **Product/Item/Unit:** Egg Salad**; Temperature Process:** Cooling
Location: Display Cooler at 46.5 Degrees F.
Comment: Main Kitchen 2. Cooling for 1 hour.
Violation Issued?: No

Food Temperature: **Product/Item/Unit:** Sliced Tomatoes**; Temperature Process:** Time as Public Health Control
Location: Ice Bath at 40.5 Degrees F.
Comment: Main kitchen 2. Inspector discussed using/serving TCS foods within 4 hours or discarding after the 4 hour limit. However, if the establishment wants to save the TCS foods, the TCS foods need to held under mechanical refrigeration during the whole serving period.

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** Sloppy Joes**; Temperature Process:** Cooling
Location: Prep Cooler at 43.9 Degrees F.
Comment: Main Kitchen 2. Cooling for 2 hours.
Violation Issued?: No

Food Temperature: **Product/Item/Unit:** Sauerkraut **; Temperature Process:** Cold-Holding
Location: Prep Cooler at 40.5 Degrees F.
Comment: Main Kitchen 2.
Violation Issued?: No

Food Temperature: **Product/Item/Unit:** Milk**; Temperature Process:** Cold-Holding
Location: Server Station Counter Prep Cooler at 39 Degrees F.
Comment: Main Kitchen 2.
Violation Issued?: No

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

Sanitizer Observations/Recordings

Establishment Info

FARMSTEAD CARE OF MOORHEAD LP
Moorhead
County/Group: Clay County

Inspection Info

Report Number: F1049261015
Inspection Type: Full
Date: 1/26/2026
Time: 11:15 AM

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** Wiping Cloth Bucket
Location: Kitchen 2 - Prep Area **Equal To** 100 PPM
Comment: PIC REFRESHED BUCKET. WIPING CLOTH BUCKET THEN RETESTED AT 200 PPM.
Violation Issued?: Yes

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Kitchen 1 - Dishwashing Area **Equal To** 168.1 Degrees F.
Comment: Main Kitchen 1
Violation Issued?: No

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** Wiping Cloth Bucket
Location: Kitchen 1 - Prep Area **Equal To** 200 PPM
Comment: Main Kitchen 1
Violation Issued?: No

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** Wiping Cloth Bucket
Location: Kitchen 2 - Server Station **Equal To** 200 PPM
Comment:
Violation Issued?: No

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Kitchen 2 - Dishwashing Area **Equal To** 163.2 Degrees F.
Comment:
Violation Issued?: No

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL31557016	**Date:** 1/26/2026
Facility Name: Farmstead Care of Moorhead	
Facility Address: 3200 28th Street, Moorhead, MN 56560	

☒ **TAG IDENTIFICATION: 0775**

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

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

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

   Comments: The emergency exit door in the south wing of memory care and door # 2 in the Farmstead Villa, did not have the snow removed so that there was a clear pathway leading to a public way.

3. Controlled egress doors shall: unlock upon activation of either the automatic sprinkler system or smoke detection system, unlock upon loss of power controlling the lock, have the capability of being unlocked by a signal or switch from the fire command center, nursing station, or other approved location. [Minn. Stat. 144G.45 subd. 2; MSFC 1010.1.9.7]

   Comments: The emergency exit doors leading outside had a keypad that required a code to unlock the doors. When interviewed about the controlled egress locking system, director of maintenance (DM)-D stated that there was no manual override for the controlled egress locks in the memory care unit.

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

   Comments: The fire door going into the laundry room on the north wing, was propped open by a door holder that does not release upon the fire alarm going off.