DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

May 20, 2026

Licensee
Farmside Senior Living
823 State Highway 371 Northwest
Backus, MN 56435

RE: Project Number(s) SL30674016

Dear Licensee:

On April 23, 2026, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on October 23, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the October 23, 2025 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on October 23, 2025, found not corrected at the time of the April 23, 2026, follow-up survey and/or subject to penalty assessment are as follows:

0775-Fire Protection And Physical Environment-144g.45 Subd. 2. (a) - $1,000.00
0780-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (1)

The details of the violations noted at the time of this follow-up survey completed on April 23, 2026 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Also, at the time of this follow-up survey completed on April 23, 2026, we identified the following violation(s):

0340-Correction Orders-144g.30 Subd. 5 - $500.00

The details of the violation(s) noted at the time of this follow-up survey are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these state correction orders. It is not necessary to develop a plan of correction.

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

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

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

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

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

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

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

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

We urge you to review these orders carefully. If you have questions, please contact Stephanie Jones

de Palma at 651-201-4320.

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

Sincerely,

Stephanie Jones de Palma, Supervisor
State Evaluation Team
Email: stephanie.jones.de.palma@state.mn.us
Telephone: 651-201-4320 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
	30674	A. BUILDING: _____ B. WING _____	R 04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FARMSIDE SENIOR LIVING	823 STATE HIGHWAY 371 NW BACKUS, MN 56435

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS 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: SL30674016-2 On April 21, 2026, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to surveys completed on February 5, 2026, and October 23, 2025. At the time of the second follow-up survey, there were 10 residents; 10 receiving services under the Assisted Living Facility license. As a result of the second follow-up survey, the following orders were reissued and a new order identified.	{0 000}		
0 340 SS=F	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or staff of the facility is not in compliance with this chapter. The correction order shall cite the	0 340		

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0 340	Continued From page 1 specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must: (1) document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed; and This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to document in the facility's records any action taken to comply with the correction orders for the 0775 and 0780 tags. This had the potential to directly affect all building occupants. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 340		

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0 340	Continued From page 2 The findings include: On April 22, 2026, at 2:09 p.m., the surveyor emailed the owner (O)-K and requested a plan of correction for the 0775 and 0780 tags. The surveyor directed O-K to provide the plan of correction no later than 9:00 a.m. on April 23, 2026. On April 22, 2026, at 2:24 p.m. O-K responded they were unaware of the site visit yesterday, and had not received the specific documentation or information regarding the tags the surveyor mentioned. O-K requested that the surveyor send over the details regarding the requested corrections. On April 22, 2026, at 3:17 p.m., the surveyor emailed O-K a copy of the orders from the February 5, 2026, follow-up survey that were delivered electronically to O-K on March 3, 2026. A plan of correction for the 0775 and 0780 tags were not provided to the surveyor as of April 23, 2026. By the correction order date, the facility must document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed. [Minn. Stat. 144G.30 subd.5] TIME PERIOD FOR CORRECTION: Seven (7) days	0 340		
{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	{0 480}		

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{0 480}	Continued From page 3 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part	{0 480}		

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{0 480}	Continued From page 4 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by:	{0 480}	Not reviewed during this survey.	
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are	{0 680}		

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{0 680}	Continued From page 5 allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by:	{0 680}	Not reviewed during this survey.	
{0 775} SS=I	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to comply with Minnesota Fire Code, Minnesota Rules 7511. This had the potential to directly affect all building occupants. 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: On April 21, 2026, at 10:00 a.m., during the second survey follow-up, the surveyor toured the facility with manager (M)-M. During the facility tour, the surveyor observed the following:	{0 775}		

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{0 775}	Continued From page 6 EGRESS DOOR LOCKING Key only locks were installed on the exit door for the main entrance (west living room) and on the door leading into the attached garage. Illuminated exit signs were installed above both of these doors. Egress doors shall be readily operable from the egress side without the use of a key or special knowledge. [Minn. Stat. 144G.45 subd. 2; MSFC 1010.1.9] SMOKE ALARM MAINTENANCE - There was an empty bracket for hardwired smoke alarm in the basement. - Smoke alarms over 10 years from date of manufacture were installed in multiple locations of the building. Single and multiple-station smoke alarms shall be replaced when they exceed ten years from the date of manufacture. Smoke alarms shall be replaced with smoke alarms having the same type of power supply. [Minn. Stat. 144G.45 subd. 2; MSFC 1103.8.1] EMERGENCY EXITS An illuminated exit sign was installed at the door leading into the attached garage from the building. This door was labeled as an exit on the posted evacuation floor plans. Emergency exits are required to lead directly to the exterior of the building and not through a higher-hazard room. During the facility tour interview, M-M verified the above listed observations.The licensee was still not compliant on the date of the second survey follow up. No additional information was provided. Previous survey findings:	{0 775}		

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{0 775}	Continued From page 7 On February 5, 2026, at 11:40 a.m., during the first survey follow-up, the surveyor toured the facility with owner (O)-K and contractor (C)-L. During the tour, the surveyor observed the following: EGRESS DOOR LOCKING Battery operated keypad locks were installed on the emergency exit door for the main entrance (west living room) and the exit door leading into the attached garage. A code entered into the keypad was required to unlock these doors. Any egress door in a locked facility must interconnect with the fire safety systems and default to an unlocked position under activation of the fire alarm, fire sprinkler system, or a loss of power. Additionally, locks requiring a key were installed on the main entrance and garage exit doors. Emergency exit doors are required to open with a single action and without the use of keys, tools, or special knowledge. Emergency exit door locking systems are required to comply with MSFC in Minnesota Rules Chapter 7511. SMOKE ALARM MAINTENANCE - There was an empty bracket for hardwired smoke alarm in the basement. Hard-wired smoke alarms shall be maintained where installed with the same type of power supply. - Smoke alarms over 10 years from date of manufacture were installed in multiple locations of the building. Smoke alarms are required to be maintained with a manufacture date of ten years or less. EMERGENCY EXITS An illuminated exit sign was installed at the door leading into the attached garage from the building. This door was labeled as an exit on the posted evacuation floor plans. Emergency exits	{0 775}		

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{0 775}	Continued From page 8 are required to lead directly to the exterior of the building and not through a higher-hazard room. During the facility tour interview, O-K and C-L verified the above listed observations and the licensee was still not compliant on the day of the follow up. On October 22, 2025, at 10:30 a.m., the surveyor toured the facility with contract manager (CM)-F. During the facility tour, the surveyor observed the following: EGRESS DOOR LOCKING Battery operated keypad locks were installed on the emergency exit door for the main entrance (west living room), on the east living room exit door, and the exit door leading into the attached garage. A code entered into the keypad was required to unlock these doors. Fire sprinkler and fire alarm systems were not installed in the building. Any egress door in a locked facility must interconnect with the fire safety systems and default to an unlocked position under activation of the fire alarm, fire sprinkler system, or a loss of power. Additionally, locks requiring a key were installed on these exit doors. Emergency exit doors are required to open with a single action and without the use of keys, tools, or special knowledge. Emergency exit door locking systems are required to comply with MSFC in Minnesota Rules Chapter 7511. SMOKE ALARM MAINTENANCE - There was an empty bracket for hardwired smoke alarm in the basement. Hard-wired smoke alarms shall be maintained where installed with the same type of power supply. - Smoke alarms over 10 years from date of manufacture were installed in multiple locations of	{0 775}		

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{0 775}	Continued From page 9 the building. Smoke alarms are required to be maintained with a manufacture date of ten years or less. EMERGENCY EXITS An illuminated exit sign was installed at the door leading into the attached garage from the building. This door was labeled as an exit on the posted evacuation floor plans. Emergency exits are required to lead directly to the exterior of the building and not through a higher-hazard room. During the facility tour interview, CM-F verified the above listed observations.	{0 775}		
{0 780} SS=B	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except	{0 780}		

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{0 780}	Continued From page 10 that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to provide smoke alarms that complied with fire protection requirements. This had the potential to directly affect all building occupants. This practice resulted in a level 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly, but is not found to be pervasive). The findings include: On April 21, 2026, at 10:00 a.m., during the second survey follow-up, the surveyor toured the facility with manager (M)-M. During the facility tour, the surveyor observed the following: - There was a fire alarm system installed in the building. Smoke alarm interconnection was achieved through this fire alarm system. - There were battery operated and hard wired smoke alarms installed throughout the building that were not part of the fire alarm system. Installation of battery operated smoke alarms that are not required could cause confusion in the	{0 780}		

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{0 780}	Continued From page 11 event of a fire emergency. During the facility tour interview, M-M verified the above listed observations. The licensee was still not compliant on the date of the second survey follow up. No additional information was provided. Previous survey findings: On February 5, 2026, at 11:40 a.m., during the first survey follow-up, the surveyor toured the facility with owner (O)-K and contractor (C)-L. During the tour, the surveyor observed the following: - There was a new fire alarm system installed in the building. Smoke alarm interconnection was achieved through this new fire alarm system. - There were battery operated and hard wired smoke alarms installed throughout the building that were not part of this new fire alarm system. Installation of battery operated smoke alarms that are not required could cause confusion in the event of a fire emergency. During the facility tour interview, O-K and C-L verified the above listed observations and the licensee was still not compliant on the day of the follow up. On October 22, 2025, at 10:30 a.m., the surveyor toured the facility with contract manager (CM)-F. During the tour, the surveyor observed the following: SMOKE ALARM INTERCONNECTION Smoke alarms were tested by CM-F. - When the smoke alarms installed in the resident sleeping rooms were tested, none of the other	{0 780}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30674	A. BUILDING: _____ B. WING _____	R 04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FARMSIDE SENIOR LIVING	823 STATE HIGHWAY 371 NW BACKUS, MN 56435

(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
{0 780}	Continued From page 12 smoke alarms in the building were actuated. - When the smoke alarms outside the resident sleeping rooms were tested, none of the other smoke alarms in the building were actuated. Battery operated wireless smoke alarms and hardwired smoke alarms were installed in the building. - When the battery operated wireless smoke alarms were tested, none of the other building smoke alarms were actuated. - When the hardwired smoke alarms were tested, none of the other building smoke alarms were actuated. All smoke alarms installed in the dwelling unit must be interconnected so actuation of one alarm causes all alarms in the dwelling unit to operate. During the facility tour interview, CM-F verified the above listed smoke alarm observations.	{0 780}		
{0 800} SS=D	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by:	{0 800}	Not reviewed during this survey.	

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{0 810}	Continued From page 13	{0 810}		
{0 810} SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by:	{0 810}	Not reviewed during this survey.	

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{0 810}	Continued From page 14	{0 810}		
{01620} SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs	{01620}		

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{01620}	Continued From page 15 and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by:	{01620}	Not reviewed during this survey.	
{01750} SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by:	{01750}	Not reviewed during this survey.	

Electronically Delivered

March 3, 2026

Licensee
Farmside Senior Living
823 State Highway 371 Northwest
Backus, MN 56435

RE: Project Number(s) SL30674016

Dear Licensee:

On January 15, 2026, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on October 23, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the October 23, 2025 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on October 23, 2025, found not corrected at the time of the January 15, 2026, follow-up survey and/or subject to penalty assessment are as follows:

0775-Fire Protection And Physical Environment-144g.45 Subd. 2. (a) - $1,000.00
0780-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (1)

The details of the violations noted at the time of this follow-up survey completed on January 15, 2026 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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

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

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

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

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

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

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

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

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

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

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

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

Sincerely,

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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30674	A. BUILDING: _____ B. WING _____	R 01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FARMSIDE SENIOR LIVING	823 STATE HIGHWAY 371 NW BACKUS, MN 56435

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL30674016-1 On February 5, 2026, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on October 23, 2025. As a result of the follow-up survey, the following orders were reissued.	{0 000}		
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part	{0 480}		

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{0 480}	Continued From page 1 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by:	{0 480}	Not reviewed during this survey.	
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	{0 680}		

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{0 680}	Continued From page 2 (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 680}		
{0 775} SS=I	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by:	{0 775}		

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{0 775}	Continued From page 3 Based on observation and interview, the licensee failed to comply with Minnesota Fire Code, Minnesota Rules 7511. This had the potential to directly affect one resident and all staff. 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: On February 5, 2026, at 11:40 a.m., the surveyor toured the facility with owner (O)-K and contractor (C)-L. EGRESS DOOR LOCKING Battery operated keypad locks were installed on the emergency exit door for the main entrance (west living room), on the east living room exit door, and the exit door leading into the attached garage. A code entered into the keypad was required to unlock these doors. Fire sprinkler and fire alarm systems were not installed in the building. Any egress door in a locked facility must interconnect with the fire safety systems and default to an unlocked position under activation of the fire alarm, fire sprinkler system, or a loss of power. Additionally, locks requiring a key were installed on the main entrance and garage exit doors. Emergency exit doors are required to open with a single action and without the use of keys, tools, or special knowledge. Emergency exit door locking systems are required to comply with MSFC in Minnesota Rules Chapter 7511.	{0 775}		

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{0 775}	Continued From page 4 SMOKE ALARM MAINTENANCE - There was an empty bracket for hardwired smoke alarm in the basement. Hard-wired smoke alarms shall be maintained where installed with the same type of power supply. - Smoke alarms over 10 years from date of manufacture were installed in multiple locations of the building. Smoke alarms are required to be maintained with a manufacture date of ten years or less. EMERGENCY LIGHT MAINTENANCE On the upper floor near the elevator, the emergency light installed on the wall did not work when tested by contractor (C)-L. EMERGENCY EXITS An illuminated exit sign was installed at the door leading into the attached garage from the building. This door was labeled as an exit on the posted evacuation floor plans. Emergency exits are required to lead directly to the exterior of the building and not through a higher-hazard room. During the facility tour interview, O-K and C-L verified the above listed observations and the licensee was still not compliant on the day of the follow up. Previous survey findings: On October 22, 2025, at 10:30 a.m., the surveyor toured the facility with contract manager (CM)-F. The egress window in occupied resident sleeping room 3 was opened by CM-F and measured by the surveyor. The egress window did not meet the minimum requirements for safe egress. EGRESS DOOR LOCKING Battery operated keypad locks were installed on	{0 775}		

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{0 775}	Continued From page 5 the emergency exit door for the main entrance (west living room), on the east living room exit door, and the exit door leading into the attached garage. A code entered into the keypad was required to unlock these doors. Fire sprinkler and fire alarm systems were not installed in the building. Any egress door in a locked facility must interconnect with the fire safety systems and default to an unlocked position under activation of the fire alarm, fire sprinkler system, or a loss of power. Additionally, locks requiring a key were installed on these exit doors. Emergency exit doors are required to open with a single action and without the use of keys, tools, or special knowledge. Emergency exit door locking systems are required to comply with MSFC in Minnesota Rules Chapter 7511. SMOKE ALARM MAINTENANCE - There was an empty bracket for hardwired smoke alarm in the basement. Hard-wired smoke alarms shall be maintained where installed with the same type of power supply. - Smoke alarms over 10 years from date of manufacture were installed in multiple locations of the building. Smoke alarms are required to be maintained with a manufacture date of ten years or less. EMERGENCY LIGHT MAINTENANCE On the upper floor near the elevator, the emergency light installed on the wall did not work when tested by CM-F. EMERGENCY EXITS An illuminated exit sign was installed at the door leading into the attached garage from the building. This door was labeled as an exit on the posted evacuation floor plans. Emergency exits are required to lead directly to the exterior of the	{0 775}		

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{0 775}	Continued From page 6 building and not through a higher-hazard room. During the facility tour interview, CM-F verified the above listed observations.	{0 775}		
{0 780} SS=C	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by:	{0 780}		

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{0 780}	Continued From page 7 Based on observation and interview, the licensee failed to provide smoke alarms that complied with fire protection requirements. This had the potential to directly affect all building occupants. This practice resulted in a level 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: On February 5, 2026, at 11:40 a.m., the surveyor toured the facility with owner (O)-K and contractor (C)-L. During the tour, the surveyor observed the following: - There was a new fire alarm system installed in the building. Smoke alarm interconnection was achieved through this new fire alarm system. - There were battery operated and hard wired smoke alarms installed throughout the building that were not part of this new fire alarm system. Installation of battery operated smoke alarms that are not required could cause confusion in the event of a fire emergency. During the facility tour interview, O-K and C-L verified the above listed observations and the licensee was still not compliant on the day of the follow up. Previous survey findings: On October 22, 2025, at 10:30 a.m., the surveyor toured the facility with contract manager (CM)-F. During the tour, the surveyor observed the	{0 780}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30674	A. BUILDING: _____ B. WING _____	R 01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{0 780}	Continued From page 8 following: SMOKE ALARM INSTALLATION LOCATIONS - A smoke alarm was not installed in the basement. SMOKE ALARM INTERCONNECTION Smoke alarms were tested by CM-F. - When the smoke alarms installed in the resident sleeping rooms were tested, none of the other smoke alarms in the building were actuated. - When the smoke alarms outside the resident sleeping rooms were tested, none of the other smoke alarms in the building were actuated. Battery operated wireless smoke alarms and hardwired smoke alarms were installed in the building. - When the battery operated wireless smoke alarms were tested, none of the other building smoke alarms were actuated. - When the hardwired smoke alarms were tested, none of the other building smoke alarms were actuated. All smoke alarms installed in the dwelling unit must be interconnected so actuation of one alarm causes all alarms in the dwelling unit to operate. During the facility tour interview, CM-F verified the above listed smoke alarm observations.	{0 780}		
{0 800} SS=D	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and	{0 800}		

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{0 800}	Continued From page 9 repair program. This MN Requirement is not met as evidenced by:	{0 800}	Not reviewed during this survey.	
{0 810} SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill	{0 810}		

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{0 810}	Continued From page 10 every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by:	{0 810}		
{01620} SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days.	{01620}	Not reviewed during this survey.	

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{01620}	Continued From page 11 (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by:	{01620}		
{01750} SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for	{01750}	Not reviewed during this survey.	

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{01750}	Continued From page 12 each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by:	{01750}	Not reviewed during this survey.	

Electronically Delivered

November 6, 2025

Licensee
Farmside Senior Living
823 State Highway 371 Northwest
Backus, MN 56435

RE: Project Number(s) SL30674016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 23, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

pursuant to this survey:

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

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

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

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

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in

a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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

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

If you have any questions, please contact me.

Sincerely,

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
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0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30674016-0 On October 20, 2024, through October 23, 2024, the Minnesota Department of Health conducted a change of ownership (CHOW) survey at the above provider. At the time of the survey, there were 9 residents; 9 receiving services under the Assisted Living Facility license. An immediate correction order was issued October 22, 2025, for SL30674016-0 correction order tag identification 0775. The licensee took actions to mitigate risk on October 22, 2025, however, the order remains at a scope and level of level three, widespread (I).	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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

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0 480	Continued From page 2 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 October 21, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24	0 480		

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0 480	Continued From page 3 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the missing resident policy was reviewed quarterly. This had	0 680		

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0 680	Continued From page 4 the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 October 20, 2025, at 10:45 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated the licensee was familiar with current minimum assisted living requirements. On October 21, 2025, at 1:05 p.m., CNS-B stated CNS-B had done training and missing resident drills with staff quarterly. On October 23, 2025, at 9:16 a.m., regional registered nurse consultant (RRNC)-C stated the only reviews found were the staff trainings, and the plan had not been reviewed by the LALD and CNS quarterly. The licensee's 2.28 Missing Resident policy dated March 1, 2025, indicated the [facility name] will review this policy and any individual resident plans that pertain to elopement at least quarterly, and all changes will be documented. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0110, Subp. 4, effective October	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 680	Continued From page 5 2022, the assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 775 SS=I	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with Minnesota Fire Code, Minnesota Rules 7511. This had the potential to directly affect one resident and all staff. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: EGRESS WINDOW OCCUPIED SLEEPING ROOM On October 22, 2025, at 10:30 a.m., the surveyor toured the facility with contract manager (CM)-F.	0 775		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 775	Continued From page 6 The egress window in occupied resident sleeping room 3 was opened by CM-F and measured by the surveyor. The egress window did not meet the minimum requirements for safe egress. Egress window measurements: Occupied sleeping room 3 - the clear open area of both windows measured 23 inches width, 26.25 inches height, with a total clear area of 603 square inches. One window in each resident sleeping room must meet the minimum window opening size of at least 20 inches in width and, a minimum height of 20 inches, with a total clear area of at least 648 square inches (4.5 square feet). During the facility tour interview, CM-F verified the egress window measurements. EGRESS DOOR LOCKING Battery operated keypad locks were installed on the emergency exit door for the main entrance (west living room), on the east living room exit door, and the exit door leading into the attached garage. A code entered into the keypad was required to unlock these doors. Fire sprinkler and fire alarm systems were not installed in the building. Any egress door in a locked facility must interconnect with the fire safety systems and default to an unlocked position under activation of the fire alarm, fire sprinkler system, or a loss of power. Additionally, locks requiring a key were installed on these exit doors. Emergency exit doors are required to open with a single action and without the use of keys, tools, or special knowledge. Emergency exit door locking systems are required to comply with MSFC in Minnesota Rules Chapter 7511.	0 775		

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	30674	A. BUILDING: _____ B. WING _____	10/23/2025

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0 775	Continued From page 7 OBSTRUCTED EGRESS - The egress window was obstructed by a window air conditioner unit screwed into the frame in unoccupied resident sleeping room 6. - The double hung egress window would not stay open in occupied resident sleeping room 8. - The casement egress window handle was missing in occupied resident sleeping room 2. While the surveyor was onsite, a handle was installed on the egress window, but the handle did not fit securely, making it difficult to open and close the window. - Personal items were stored on the egress window sill in occupied resident sleeping room 11. All paths of egress must provide unobstructed exiting. SMOKE ALARM MAINTENANCE - There was an empty bracket for hardwired smoke alarm in the basement. Hard-wired smoke alarms shall be maintained where installed with the same type of power supply. - Hardwired smoke alarms in occupied resident sleeping rooms 1, 5 and 11, did not work when tested by CM-F. - The hardwired smoke alarm outside resident rooms 1 and 2 did not work when tested by CM-F. - The battery wireless smoke alarms had been removed from the brackets in occupied resident sleeping rooms 5 and 11. All installed smoke alarms must be maintained as operable. - Smoke alarms over 10 years from date of manufacture were installed in multiple locations of the building. Smoke alarms are required to be maintained with a manufacture date of ten years	0 775		

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0 775	Continued From page 8 or less. CARBON MONOXIDE DETECTION Carbon monoxide alarms were not installed outside and within ten feet of resident sleeping rooms 2, 5, 6, and 9. EMERGENCY LIGHT MAINTENANCE On the upper floor near the elevator, the emergency light installed on the wall did not work when tested by CM-F. EMERGENCY EXITS An illuminated exit sign was installed at the door leading into the attached garage from the building. This door was labeled as an exit on the posted evacuation floor plans. Emergency exits are required to lead directly to the exterior of the building and not through a higher-hazard room. During the facility tour interview, CM-F verified the above listed observations. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms;	0 780		

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0 780	Continued From page 9 (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that complied with fire protection requirements. This had the potential to directly affect all building occupants. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 22, 2025, at 10:30 a.m., the surveyor	0 780		

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0 780	Continued From page 10 toured the facility with contract manager (CM)-F. During the tour, the surveyor observed the following: SMOKE ALARM INSTALLATION LOCATIONS - A smoke alarm was not installed in the basement. - A smoke alarm was not installed outside and in the immediate vicinity of occupied resident sleeping room 3. SMOKE ALARM INTERCONNECTION Smoke alarms were tested by CM-F. - When the smoke alarms installed in the resident sleeping rooms were tested, none of the other smoke alarms in the building were actuated. - When the smoke alarms outside the resident sleeping rooms were tested, none of the other smoke alarms in the building were actuated. Battery operated wireless smoke alarms and hardwired smoke alarms were installed in the building. - When the battery operated wireless smoke alarms were tested, none of the other building smoke alarms were actuated. - When the hardwired smoke alarms were tested, none of the other building smoke alarms were actuated. All smoke alarms installed in the dwelling unit must be interconnected so actuation of one alarm causes all alarms in the dwelling unit to operate. During the facility tour interview, CM-F verified the above listed smoke alarm observations. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		

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0 800	Continued From page 11	0 800		
0 800 SS=D	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all building occupants. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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: On October 22, 2025, at 10:30 a.m., the surveyor toured the facility with contract manager (CM)-F. During the tour, the surveyor observed the following:	0 800		

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0 800	Continued From page 12 - In the resident shower room, there was a hole in the wall. - The electrical wall outlet cover was cracked in the bathroom of occupied resident room 2. - The window blind was in disrepair in occupied resident room 7. During the facility tour interview, CM-F verified the above listed observations. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The	0 810		

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0 810	Continued From page 13 training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with required content, and provide required training and drills. This had the potential to directly affect all building occupants. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 22, 2025, contract manager (CM)-F provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility.	0 810		

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0 810	Continued From page 14 FIRE SAFETY AND EVACUATION PLAN The licensee failed to post the FSEP main level floor plan in a readily available location evident by the following: On October 22, 2025, at 10:30 a.m., the surveyor toured the facility with CM-F. During the tour, the surveyor observed the main level floor plan was posted in the kitchen pantry. The licensee FSEP failed to identify the location of a resident sleeping room evident by the following: On October 22, 2025, at 10:30 a.m., the surveyor toured the facility with CM-F. During the tour, the surveyor observed the number identifier "11" was posted on an occupied resident sleeping room door on the second level. Resident room 11 was labeled as an "attic room" on the undated FSEP floor plan posted in the kitchen pantry. Accurate resident sleeping room labels are to be included on the FSEP floor plan and correspond with the identifiers installed at the resident sleeping room doors to provide efficient communication for exiting in the event of a fire or similar emergency. During the facility tour interview, CM-F verified the above listed observations. Record review of the available documentation indicated the licensee failed to develop and maintain the FSEP with site specific procedures for the facility and building occupants evident by the following: - The posted 7.10 Emergency Preparedness Management Plan dated June 18, 2019, inappropriately directed the building occupants to	0 810		

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0 810	Continued From page 15 evacuate behind smoke compartment doors. - The FSEP included standard employee procedures, but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The FSEP had been created using a template from another assisted living provider. The plan inaccurately referenced fire rated corridors, a fire alarm system, pull fire alarms, and the location of the responding fire department. During an interview on October 22, 2025, at 1:30 p.m., CM-F verified the FSEP required revision. TRAINING Record review of the available documentation indicated the licensee failed to provide training to employees on the site specific FSEP at the time of hire. New hire employee training records from May 30 to September 25, 2025, for fire alarms and drills were provided. Training records for the fire safety and evacuation plan were not provided. During an interview on October 22, 2025, at 1:30 p.m., CM-F verified records for site specific FSEP training were not available. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month evident by a review of fire drill reports lacking the required frequency. Two fire drills were recorded on signature pages, dated April 18, 2025, and August 25, 2025. - Fire drills were not conducted in May, June, or July 2025.	0 810		

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0 810	Continued From page 16 - Morning, afternoon, and night shift employees participated in combined fire drills. - Fire drill reports were not completed documenting the simulated conditions. During an interview on October 22, 2025, at 1:30 p.m., CM-F stated fire drills had been perform by combing shifts, and verified the frequency and documentation were lacking. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's	01620		

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01620	Continued From page 17 needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. 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) completed a change in condition assessment following a hospice admission for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01620		

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01620	Continued From page 18 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: On October 20, 2025, at 10:45 a.m., during the entrance conference, clinical nurse supervisor (CNS)-B stated resident assessments were completed prior to admission, on admission, 14-days, every 90 days, a change in condition and hospital return. R2's diagnosis included hypertension (high blood pressure), anxiety and chronic kidney disease. On October 20, 2025, at 12:40 p.m., the surveyor observed unlicensed personnel (ULP)-D administer R2's noon scheduled medications. R2's Service Plan dated August 10, 2024, indicated R2 received assistance with medication administration, assistance with dressing, mobility, showering, safety checks, laundry, and housekeeping. R2's Progress notes (PN) dated September 10, 2025, written by clinical nurse supervisor (CNS)-B indicated CNS-B had spoken with resident's son and son would like to move forward with hospice, received order from PCP (primary care provider) and referral placed with (hospice name). R2's PN dated September 11, 2025, (note was electronically signed by CNS-B on October 21, 2025, after survey entrance date) indicated,	01620		

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01620	Continued From page 19 resident was admitted to hospice care today. Resident had sat in the living room with (hospice name) nurse and was pleasant and cooperative. R2's record indicated the RN completed a change in condition assessment on October 6, 2025, and a quarterly (90-day) assessment August 20, 2025. R2's record lacked a change of condition assessment following hospice admission on September 11, 2025. On October 21, 2025, at 1:04 p.m., CNS-B stated CNS-B was on vacation and did not complete the change of condition assessment until after CNS-B returned from vacation. CNS-B stated change of condition assessments are normally done right away and the on-call nurse should have completed the change in condition assessment. The licensee's 6.01 Assessments, Reviews and Monitoring policy dated March 1, 2023, indicated ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated	01750		

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FARMSIDE SENIOR LIVING	823 STATE HIGHWAY 371 NW BACKUS, MN 56435

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01750	Continued From page 20 to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure as needed (PRN) medications included parameters for administration for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's diagnosis included hypertension (high blood pressure), anxiety and chronic kidney disease. On October 20, 2025, at 12:40 p.m., the surveyor observed unlicensed personnel (ULP)-D administer R2's noon scheduled medications. R2's Service Plan dated August 10, 2024,	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30674	A. BUILDING: _____ B. WING _____	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FARMSIDE SENIOR LIVING	823 STATE HIGHWAY 371 NW BACKUS, MN 56435

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01750	Continued From page 21 indicated R2 received assistance with medication administration, assistance with dressing, mobility, showering, safety checks, laundry, and housekeeping. R2's record indicated the registered nurse (RN) completed a change in condition assessment on October 6, 2025, and a quarterly (90-day) assessment August 20, 2025, which both assessments indicated R2 was unable to manage medications due to decreased cognition. R2's September 15, 2025, through October 31, 2025, electronic medication administration record (EMAR) indicated the following PRN medications: -morphine 5 milligrams(mg)/0.25 milliliter (ml), give one syringe (5 mg /0.25 ml) every four hours PRN for pain; -acetaminophen 500 mg, one tablet every six hours PRN; and -acetaminophen 325 mg, two tablets every four hours PRN. R2's September 2025 EMAR indicated R2 received the following PRN medications as above: -morphine 5 mg/0.25 mg on September 15, and 21; -acetaminophen 500 mg on September 4, 9, 14, 15, and 17; and -acetaminophen 325 mg on September 7, 16, and 26. R2's October 2025 EMAR indicated R2 received the following PRN medications as above: -acetaminophen 325 mg on October 20. R2's progress notes from September 1, 2025,	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30674	A. BUILDING: _____ B. WING _____	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FARMSIDE SENIOR LIVING	823 STATE HIGHWAY 371 NW BACKUS, MN 56435

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01750	Continued From page 22 through October 21, 2025, did not include nurse notes in regards to which PRN pain medication to be administered first. R2's master care plan dated October 6, 2025, did not include specific instructions for PRN pain medications. R2's Individualized Medication Management Plan dated October 6, 2025, did not include specific instructions for PRN pain medications. R2's record lacked specific written instructions for R2's PRN pain medications, including parameters to indicate which pain medication to be administered first. On October 21, 2025, at 1:02 p.m., clinical nurse supervisor (CNS)-B stated the EMAR did not have specific instruction for which pain medication to administer first. CNS-B stated the ULPs would call the nurse and ask for guidance on which pain medication to administer first. The licensee's 7.15 Medication & Treatment - Administration & Delegations policy dated March 1, 2025, indicated when administration of medications or treatment/therapy is delegated or assigned to unlicensed personnel, (facility) will ensure that the RN has: -specified, in writing, specific instructions for each resident and documented those instructions in the resident's records. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		

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

Food & Beverage Inspection Report

Establishment Info

Farmside Senior Living
823 State Highway 371 NW
Backus, MN 56435
Cass County
Parcel:

Phone:

License Info

License: HFID 30674

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

Inspection Info

Report Number: F1040251063
Inspection Type: Full - Single
Date: 10/21/2025 Time: 2:44:15 PM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 1
Total Priority 2 Orders: 3
Total Priority 3 Orders: 3
Delivery:

New Order: 2-100 Supervision
2-102.12AMN *Priority Level: Priority 3 CFP#: 2*
MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.
COMMENT: AT TIME OF INSPECTION NO CERTIFIED FOOD PROTECTION MANAGER EMPLOYED
Comply By: 1/21/2026 Originally Issued On: 10/21/2025

New Order: 3-300C Protection from Contamination: equipment/utensils, consumers
3-305.11A *Priority Level: Priority 3 CFP#: 39*
MN Rule 4626.0300A Store all food in a clean, dry location; where it is not exposed to splash, dust or other contamination; and at least 6 inches above the floor.
COMMENT: AT TIME OF INSPECTION BULK FOOD SUCH AS SUGAR AND RICE IS BEING STORED IN FLOOR IN DRY STORAGE
Comply By: 10/21/2025 Originally Issued On: 10/21/2025

New Order: 4-100 Equipment Construction Materials
4-101.11BCDE *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0450BCDE Remove all multi-use equipment, utensils, and food storage containers that are not durable, corrosion-resistant, nonabsorbent, smooth, easily cleanable, resistant to pitting, chipping, scratching or not able to withstand repeated warewashing.
COMMENT: OBSERVED PLASTIC PLATES WITH SCRATCHES IN CUPBOARD, INSTRUCTED TO DISCARD, CHIPPED BOWLS INSTRUCTED TO DISCARD
Comply By: 10/21/2025 Originally Issued On: 10/21/2025

New Order: 4-300 Equipment Numbers and Capacities
4-302.14 *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.
COMMENT: AT TIME OF INSPECTION NO QUATERNARY AMMONIA TEST STRIPS AVAILABLE
Comply By: 10/28/2025 Originally Issued On: 10/21/2025

! **New Order: 5-100 Water**
5-102.11 *Priority Level: Priority 1 CFP#: 31*
MN Rule 4626.0995 Water must be obtained from a public water system that complies with the requirements of chapters 4714, 4720, and 4725. Water acquired from a nonpublic water system must meet the drinking water quality standards for noncommunity transient water systems.
COMMENT: AT TIME OF INSPECTION NO KNOWN WATER TESTING HAS OCCURRED AT SITE FOR YEARS
Comply By: 11/21/2025 Originally Issued On: 10/21/2025

New Order: 5-100 Water
5-102.13 *Priority Level: Priority 2 CFP#: 31*
MN Rule 4626.1005 Water from a public water system must be sampled and tested as required by chapter 4720, rules for public water supplies.
COMMENT: AT TIME OF INSPECTION DIRECTOR STATED SITE HAS LIKELY NOT BEEN TESTING WATER, WATER IS REQUIRED TO BE TESTED ANNUALLY FOR COLIFORMS, NITRATES, AND NITRITES
Comply By: 11/21/2025 Originally Issued On: 10/21/2025

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control
6-501.115AB *Priority Level: Priority 2 CFP#: 38*
MN Rule 4626.1585AB Remove all live animals from the establishment except as specified in rule.
COMMENT: AT TIME OF INSPECTION BIRDS ARE BEING KEPT IN A COMMON DINING AREA WITH NO PARTITIONING AND SELF-CLOSING DOORS BETWEEN KITCHEN AND BIRDS
4626.1585 B) (4) pets in the common dining areas of institutional care facilities at times other than during meals if:
(a) effective partitioning and self-closing doors separate the common dining areas from food storage or food preparation areas;
(b) condiments, equipment, and utensils are stored in enclosed cabinets or removed from the common dining areas when pets are present; and
§(c) dining areas including tables, countertops, and similar surfaces are effectively cleaned before the next meal service; and
Comply By: 12/16/2025 Originally Issued On: 10/21/2025

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

I acknowledge receipt of the Bemidji District Office inspection report number F1040251063 from 10/21/2025

Establishment Representative

Vania Jeh,
Public Health Sanitarian 1
218-308-2124
vania.jeh@state.mn.us

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

Temperature Observations/Recordings

Establishment Info

Farmside Senior Living
Backus
County/Group: Cass County

Inspection Info

Report Number: F1040251063
Inspection Type: Full
Date: 10/21/2025
Time: 2:44:15 PM

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

Equipment Temperature: Product/Item/Unit: REFRIGERATOR/FREEZER 2, AMBIENT TEMPERATURE**; Temperature Process:** Cold-Holding
Location: Upright Freezer at 0 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: REFRIGERATOR/FREEZER 1, COTTAGE CHEESE**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 41 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: REFRIGERATOR/FREEZER 1, AMBIENT TEMPERATURE**; Temperature Process:** Cold-Holding
Location: Upright Freezer at Degrees F.
Comment:
Violation Issued?: No

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

Sanitizer Observations/Recordings

Establishment Info

Farmside Senior Living
Backus
County/Group: Cass County

Inspection Info

Report Number: F1040251063
Inspection Type: Full
Date: 10/21/2025
Time: 2:44:15 PM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Kitchen **Equal To** Degrees F.
Comment: UNABLE TO TEST AS SANITIZE SETTING TAKES OVER 4 HOURS, MANAGER SHOWED PAST TESTING WITH THERMOLABELS OVER 160F
Violation Issued?: No

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** Spray Bottle
Location: Kitchen **Equal To** PPM
Comment:
Violation Issued?: No