Electronically Delivered

December 22, 2025

Licensee
Midwest Care Facilities dba Autumn Hills
2528 Park Avenue Northwest
Bemidji, MN 56601

RE: Project Number(s) SL30484016

Dear Licensee:

On December 12, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on August 20, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

CLN

Electronically Delivered

October 6, 2025

Licensee
Midwest Care Facilities Dba Autumn Hills
2528 Park Avenue Northwest
Bemidji, MN 56601

RE: Project Number(s) SL30484016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 20, 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:

0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $1,000.00
0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - $1,000.00
1290 - 144g.60 Subdivision 1 - Background Studies Required - $1,000.00
2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $6,000.00**. 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 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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30484	A. BUILDING: _____ B. WING _____	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST CARE FACILITIES DBA AUTUMN HIL	2528 PARK AVENUE NW BEMIDJI, MN 56601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30484016-0 On August 18, 2025, through August 20, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 23 residents; 23 receiving services under the Provisional Assisted Living Facility with Dementia Care license. An immediate correction order was issued August 18, 2025, for SL30484016-0 correction order tag identification 1290. The licensee took actions to mitigate risk on August 19, 2025, however, the order remains at a scope and level of level three, widespread (I). An immediate correction order was issued August 19, 2025, for SL30484016-0 correction order tag identification 2310. The licensee took actions to mitigate risk on August 20, 2025,	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.	

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0 000	Continued From page 1 however, the order remains at a scope and level of level four, widespread (K).	0 000		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview, observation, and record review, the licensee failed to ensure the clinical	0 470		

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0 470	Continued From page 2 nurse supervisor (CNS) reviewed the staffing plan at least twice a year. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: The licensee held an assisted living facility license for a capacity of 31 residents and had a current census of 23 residents. During the entrance conference on August 18, 2025, at 9:30 a.m., assisted living director in residency (ALDIR)-A and CNS-B stated the staffing schedule was as follows: -day shift: one unlicensed personnel (ULP) medication passer, and three ULP floor staff from 7:00 a.m. - 3:00 p.m.; -evening shift: one ULP medication passer, and three ULP floor staff from 3:00 p.m. - 11:00 p.m.; and -night shift: one ULP medication passer, and one ULP floor staff from 11:00 p.m. - 7:00 a.m. On August 18, 2025, at 11:30 a.m., the surveyor observed a daily staffing schedule posted outside the nurse's office in the hallway. On August 20, 2025, at 1:05 p.m., CNS-B stated the licensee had a staffing plan, however, was unaware the plan needed to be reviewed twice a	0 470		

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0 470	Continued From page 3 year. The licensee's Assisted Living Staffing Plan dated May 16, 2025, indicated an evaluation will be completed at least twice a year, of the appropriateness of staffing at the above facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and	0 480		

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0 480	Continued From page 4 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: 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	0 480		

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0 480	Continued From page 5 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 August 19, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 490 SS=F	144G.41 Subdivision 1b Minimum requirements; other required services All assisted living facilities must offer to provide or make available the following services to residents: (1) weekly housekeeping; (2) weekly laundry service; (3) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (4) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible	0 490		

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0 490	Continued From page 6 for providing this assistance; (5) provide culturally sensitive programs; and (6) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have daily programs of social and recreational activities based on individual and group interests, physical, mental, and psychosocial needs. This had the potential to affect all 23 residents at 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) 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: During the entrance conference on August 18, 2025, at 9:30 a.m., assisted living director in residency/licensed practical nurse (ALDIR/LPN)-A stated the licensee did not have a daily program of social and recreational activities or an activity calendar posted. ALDIR/LPN-A stated the dietary staff had planned various activities for the residents when dietary staff have time. ALDIR/LPN-A was aware	0 490		

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0 490	Continued From page 7 an activity calendar needs to be posted and was on ALDIR/LPN-A's list of things to be completed. During the facility tour on August 18, 2025, at 10:30 a.m., the surveyor did not observe an activity calendar posted in the facility. On August 18, 2025, at 11:40 a.m., the surveyor interviewed R2. R2 stated she does not receive an activity calendar. R2 stated there was not many activities, occasionally staff may do an activity with the residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 490		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement and maintain a	0 580		

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0 580	Continued From page 8 quality management program appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all 23 residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: During the entrance conference on August 18, 2025, at 9:30 a.m., assisted living director in residency/licensed practical nurse (ALDIR/LPN)-A stated the licensee did not have a quality management plan or documentation of meetings that she was aware of. ALDIR/LPN-A stated she was still in the learning process and was planning to start a quality management plan. A policy was requested, however was not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		
0 650 SS=E	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services.	0 650		

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0 650	Continued From page 9 The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records contained the required content for two of three employees (cook (C)-F, clinical nurse supervisor (CNS)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not	0 650		

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0 650	Continued From page 10 found to be pervasive). The findings include: During the entrance conference on August 18, 2025, at 9:30 a.m., assisted living director in residency/licensed practical nurse (ALDIR/LPN)-A stated the licensee was aware of required content in an employee record. C-F C-F was hired June 14, 2024, to provide indirect care services to the residents of the facility. C-F's employee record lacked the following: -a job description; -records of orientation and infection control training; -evidence an annual performance review that defined areas of improvement needed and training needs had been completed; and -documentation of the background study as required under section 144.047. CNS-B CNS-B was hired April 23, 2025, to supervise and provide direct care services to the residents of the facility. CNS-B's employee record lacked the following: -job description. On August 20, 2025, at 11:19 a.m., ALDIR/LPN-A stated CNS-B did not have a job description in her employee record, and ALDIR/LPN-A had CNS-B sign a job description on August 19, 2025 (after survey entrance date). On August 20, 2025, at 1:05 p.m., ALDIR/LPN-A	0 650		

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	30484	A. BUILDING: _____ B. WING _____	08/20/2025

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0 650	Continued From page 11 stated C-F did not have many documents in his employee record. ALDIR/LPN-A stated C-F started employment before ALDIR/LPN-A and ALDIR/LPN-A was not aware C-F was missing the required documents. The licensee's undated Employee Records policy indicated every employee of [facility name] shall have a personnel file created upon hire. The employee file shall contain: -verification of the Department of Human Services (DHS) background study response; -when appropriate, training regarding Alzheimer's disease and related disorders; -record of orientation (including required elements); -documentation of annual performance review which identify areas of improvement needed and training needs; and -a current job description, which includes qualifications, responsibilities and identification of staff responsible for supervision. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must	0 660		

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0 660	Continued From page 12 include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) and Minnesota Department of Health (MDH), including completion of a Facility TB Risk Assessment, Baseline TB Screening Tool for Healthcare Workers (HCWs), and a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for two of three employees (cook (C)-F, clinical nurse supervisor (CNS)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: During the entrance conference on August 18, 2025, at 9:30 a.m., assisted living director in residency/licensed practical nurse	0 660		

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0 660	Continued From page 13 (ALDIR/LPN)-A and clinical nurse supervisor (CNS)-B stated ALDIR/LPN-A and CNS-B were aware of the TB Risk Assessment requirement, however the assessment had not been completed. ALDIR/LPN-A stated on hire, the staff fill out a symptom screen and will have a QuantiFERON drawn at occupational health. The licensee's incomplete, undated Facility TB Risk Assessment for Health Care Settings Licensed by MDH indicated the facility was determined to be a low risk level. C-F C-F was hired June 14, 2024, to provide indirect care services to the residents of the facility. C-F's employee record contained a negative Baseline TB Screening Tool for HCWs dated June 12, 2024. C-F 's employee record lacked evidence of completion of a two-step TST or other evidence of TB screening such as a blood test. CNS-B CNS-B was hired April 23, 2025, to supervise and provide direct care services to the residents of the facility. CNS-B's employee record contained a negative Baseline TB Screening Tool for HCWs dated August 19, 2025 (after survey entrance date). In addition, CNS-B 's employee record indicated step one of the TST was completed on April 28, 2025, however, lacked evidence step 2 was completed of a two-step TST. On August 20, 2025, at 11:10 a.m., ALDIR/LPN-A	0 660		

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0 660	Continued From page 14 stated ALDIR/LPN-A could not find a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for C-F and was unsure why it was not completed. In addition, ALDIR/LPN-A stated a Baseline TB screening for HCW was completed for CNS-B on August 19, 2025, after survey entrance date. ALDIR/LPN-A stated she was unsure why the second TST test was not completed. The licensee's 8.16 Tuberculosis Screening policy dated July 21, 2022, indicated the facility will maintain a current community TB risk assessment. The assessment will be updated annually, using the data and form provided by MDH. Staff screening will be conducted as follows: -new staff will be screened for active signs of TB using TB Screening Tool for HCWs; -new staff will have an IGRA (a blood test used to detect latent tuberculosis infection) blood test or a two-step Mantoux conducted with results documented on the Baseline TB Screening Tool for HCWs; -no staff will be permitted to begin work where the work involves sharing the air space with residents until the negative results of the first Mantoux are read and documented or a negative IGRA blood test result is received and documented; and -staff TB screening results will be kept in each employee medical file. The Regulations for TB Control in Minnesota Health Care Settings dated July 2013, indicated a baseline TB screening is required for all HCWs upon hire, and included administering a two-step TST or single blood draw to screen for active TB.	0 660		

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0 660	Continued From page 15 The MDH TB Screening and Education Requirements for Assisted Living Facilities and Home Care Providers dated February 3, 2022, indicated baseline TB screening is required at the time of hire for all health care personnel in Minnesota. Baseline TB screening includes assessing for current symptoms of active TB disease; assessing TB history; and testing for the presence of infection with Mycobacterium TB by administering either a two-step TB skin test or a single TB blood test. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
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	0 680		

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0 680	Continued From page 16 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 post the written emergency preparedness plan (EPP) prominently, and failed to ensure the EPP was reviewed annually. In addition, the licensee failed to ensure the missing resident policy was reviewed quarterly. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 August 18, 2025, at 9:30 a.m., assisted living director in residency/licensed practical nurse (ALDIR/LPN)-A stated the licensee was familiar with current minimum assisted living requirements. During the facility tour on August 18, 2025, from	0 680		

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0 680	Continued From page 17 10:30 a.m. to 11:35 a.m. with ALDIR/LPN-A, the surveyor did not observe the location of the EPP posted. The licensee's EPP was last reviewed on June 14, 2023, by general manager (GM)-H. On August 19, 2025, at 9:25 a.m., ALDIR/LPN-A stated the EPP was usually in a locked office and the location of the EPP was not posted prominently. ALDIR/LPN-A stated ALDIR-A was unaware the EPP needed to be readily available and the location of the EPP needed to be posted in a prominent area of the facility. On August 20, 2025, at 1:15 p.m., ALDIR/LPN-A stated the EPP had not been reviewed since June 14, 2023, and ALDIR-A had not had time to review the EPP since taking over as ALDIR/LPN. In addition, ALDIR/LPN-A stated the missing resident policy was not reviewed quarterly and was unaware of the requirement. The licensee's Emergency Plan policy dated June 5, 2023, indicated the plan and procedures are reviewed at least annually or whenever new information or lessons learned necessitate a change. Corresponding policies and procedures will be reviewed and updated as applicable. It is essential to maintain a master copy of the EPP in a secure location in the facility. Copies of the plan are distributed to appropriate departments and units within the facility. The licensee's Missing Resident policy dated July 21, 2022, 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.	0 680		

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0 680	Continued From page 18 Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0110, Subp. 4, effective October 2022, the assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0100, sections A and B, effective October 2022, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service	0 730		

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0 730	Continued From page 19 providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced	0 730		

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0 730	Continued From page 20 by: Based on interview and record review, the licensee failed to ensure resident records included a discharge summary with the required content for one of one discharged resident (R3). 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: R3's diagnoses included diabetes, hyperlipidemia (high cholesterol), and hyperparathyroidism (parathyroid gland over produces the parathyroid hormone). R3 began receiving services on April 1, 2024, and was discharged on May 14, 2025. R3's progress notes, dated May 14, 2025, indicated R3 was discharged from the facility. R3's record lacked a discharge summary. On August 19, 2025, at 10:30 a.m., assisted living director in residency/licensed practical nurse (ALDIR/LPN)-A stated no discharge summary was completed, only a progress note, and was unaware a discharge summary was needed. No further information was provided.	0 730		

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0 730	Continued From page 21 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
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 the requirements of the Minnesota State Fire Code. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a facility tour on August 19, 2025, from 9:45 a.m. to 11:30 a.m., with general manager (GM)-H, the following observations were made of non-compliance with the requirements of the Minnesota State Fire Code (MSFC) in Minnesota Rules Chapter 7511: CIGARETTE BUTT DISPOSAL	0 775		

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0 775	Continued From page 22 There were cigarette butts on the ground next to the building outside in the designated smoking area. There was an appropriate dispenser provided in the designated smoking area. It was explained that cigarette butts and smoking materials are required to be discarded in the approved container to prevent re-ignition and spreading fire to the building. AUTOMATIC DOOR CLOSERS The main laundry room door was not provided with a closing device to automatically close and latch the laundry room door near the front main entrance and offices. It was explained that laundry rooms (incidental use areas) are required to be provided with doors that automatically close and latch to prevent the spread of smoke and fire to the corridor exit path. The fire-resistant rated cross corridor doors did not positively latch when tested for operation near resident sleeping room 30. It was explained that fire-resistant rated doors are required to be maintained to automatically close and latch to prevent the spread of smoke and fire in order to provide a means of escape in the event of a fire. EXIT DOOR LOCKS The marked exterior exit door lock did not operate as designed to exit the building near resident sleeping room 25. When tested for operation from the locked position the door	0 775		

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0 775	Continued From page 23 hardware did operate in one operation to unlatch the door in order to exit the building. It was explained that exterior exit door hardware is required to be maintained as designed and installed and to open to exit with one operation. EXIT LIGHTING The exit lighting was tested and several of the exit lights did not operate as required to provide backup power to continuously light the exit sign in the event of a power failure. It was explained that exit lights are required to be illuminated at all times the building is occupied. Backup power is required to light the signs during a power outage to provide visibility of the exit signs for occupants to navigate to an exit door. CARBON MONOXIDE DETECTION SYSTEMS There were carbon monoxide detectors observed in the boiler rooms and tied into the building fire alarms system. There were not carbon monoxide detectors observed and tied into the building fire alarm system near the attached garage, commercial kitchen, and the laundry/ boiler room/ mechanical room near the main front entrance and offices. It was explained that carbon monoxide detection is required to be provided and tied into the building fire alarm system at all sources of carbon monoxide between the source and the sleeping area. It was explained carbon monoxide detection systems are required to be installed according to	0 775		

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0 775	Continued From page 24 MSFC in Minnesota Rules Chapter 7511. ELECTRICAL There was an orange electrical extension cord used to power the ice machine in the dinning room area. During the tour GM-H, stated the outlets near the ice machine would not power the coffee maker and ice machine at the same time without tripping the ground fault interrupter so the cord was used to power the ice machine. It was explained that electrical extension cords shall not be used as a permanent power source. There was an electrical box missing the cover with wires hanging from the box near the ceiling mounted garage heater. It was explained that all electrical connections shall be completed and the covers maintained in place as designed and installed at the time of construction approval. FIRE SPRINKLER HEAD MAINTENANCE There was a fire sprinkler head on the ceiling covered with paint on the deflector and had lint covering the fusible link. It was explained fire sprinkler heads shall be maintained clear of paint and debris that effect the collection of heat required to activate the fire sprinkler head as designed. During the facility tour GM-H, verified the above listed observations while accompanying on the tour.	0 775		

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	30484	A. BUILDING: _____ B. WING _____	08/20/2025

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0 775	Continued From page 25 TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 810 SS=I	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.	0 810		

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0 810	Continued From page 26 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, make the plan readily available, provide required training and drills. This had the potential to directly affect all residents, staff, and visitors. 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: During observation on August 19, 2025, at 9:10 a.m., the surveyor observed the fire safety and evacuation plan was not located in a central location for all staff and occupants accessibility. The plan was located in the locked medication/ office only accessible by employees. On August 19, 2025, at 9:10 a.m., documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility were requested from general manager (GM)-H. FIRE SAFETY AND EVACUATION PLAN The licensee provided the Emergency Preparedness Binder updated June 14, 2023, the	0 810		

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0 810	Continued From page 27 Emergency Plan failed to include the FSEP. It was explained the FSEP is required to included employee procedures/ actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The FSEP was not available for review. It was explained the FSEP is required to included resident procedures/ actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The FSEP was not available for review. During an interview on August 19, 2025, at 9:15 a.m., GM-H, stated the FSEP was not available. TRAINING Record review of the available documentation indicated the licensee failed to provide training to employees on the FSEP upon hire and at least twice per year as evident by not providing any documentation employee training was completed as required. Record review of the available documentation indicated the licensee failed to provide evacuation training to residents at least once per year as evident by not providing documentation the required resident training was provided annually. During an interview on August 19, 2025, at 9:20 a.m., GM-H, stated documentation for training of employees and residents was not available. DRILLS	0 810		

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0 810	Continued From page 28 Record review of the available documentation indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month as evident by not providing documentation evacuation drills were completed as required. During an interview on August 19, 2025, at 9:25 a.m., GM-H, stated documentation was not available indicating evacuation drills were completed every other month and twice per year per shift. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement	01060		

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01060	Continued From page 29 that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, or designated representative and failed to provide the notification to the Office of Ombudsman for Long-Term Care of the emergency relocation for one of one resident (R3) who was hospitalized. 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	01060		

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01060	Continued From page 30 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: R3's diagnoses included diabetes, hyperlipidemia (high cholesterol), and hyperparathyroidism (parathyroid gland over produces the parathyroid hormone). R3's Progress Notes included the following: -March 14, 2025, at 11:11 a.m., R3 had an unwitnessed fall, emergency medical services (EMS) were called as R3 was complaining of left hip pain, R1 admitted to the hospital; -March 14, 2025, at 12:19 p.m., R3 was having surgery today at 3:00 p.m.; -March 24, 2025, at 11:57 a.m., R3 discharged from hospital and admitted to a skilled nursing facility (SNF); -April 10, 2025, at 1:22 p.m., R3 care conference, R3 using a mechanical Hoyer lift (a device that uses a full body sling to safely lift and transfer individuals); -April 29, 2025, at 11:50 a.m., R3 transitioned to long term care; and -May 14, 2025, at 2:33 p.m., R3 discharged from facility. R3's record lacked evidence of an emergency relocation notice with the required content. In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: -the reason for the relocation; -the name and contact information for the location to which the resident has been relocated	01060		

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01060	Continued From page 31 and any new service provider; -contact information for the Office of Ombudsman for Long-Term Care; -if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and -a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. On August 19, 2025, at 11:15 a.m., assisted living director in residency/licensed practical nurse (ALDIR/LPN)-A stated the previous clinical nurse supervisor (CNS) would have completed the emergency relocation in R3's progress notes. Furthermore, ALDIR/LPN-A and surveyor reviewed R3's notes and found no emergency relocation documentation, ALDIR/LPN-A stated the emergency relocation notifications was most likely not completed. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring	01290		

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01290	Continued From page 32 self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to obtain a cleared Department of Human Services (DHS)background study prior to providing services, for two of two employees (unlicensed personnel (ULP)-G cook (C)-F. This had the potential to affect all residents living in the facility. This resulted in an immediate correction order on August 18, 2025. 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: During the entrance conference on August 18, 2025, at 9:30 a.m., assisted living director in residency/licensed practical nurse (ALDIR/LPN)-A stated the licensee was aware of required contents in an employee record.	01290		

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01290	Continued From page 33 On August 18, 2025, at 12:43 p.m., general manager (GM)-H stated ULP-G and C-F were currently employed by the licensee. ULP-G ULP-G -was hired on February 17, 2023, to provide direct care services to the assisted living residents. ULP-G's pay history report from May 25, 2025, through August 2, 2025, indicated ULP-G's work hours ranged from 51.00 hours to 78.00 hours every two weeks. ULP-G's record included a letter dated September 25, 2023, from Minnesota Department of Health indicating, "The individual continues to have a disqualification, but you may allow him/her to provide services at the above-named program. The individual has been informed of this decision. This is our final determination unless we receive additional information that would disqualify the individual." The licensee's NetStudy 2.0 employee background study roster printed August 18, 2025, indicated ULP-G was disqualified and was to be removed from the roster. On August 18, 2025, at 1:45 p.m., GM-H stated they were responsible for ensuring employees had a cleared background study. GM-H stated he had not received any further letters for ULP-G. GM-H reviewed the NETStudy 2.0 website for any further letters regarding ULP-G. GM-H stated DHS sent a letter regarding ULP-G, which he had not previously seen. The DHS background study notice letter dated	01290		

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01290	Continued From page 34 February 15, 2025, indicated regarding ULP-G, "A request for reconsideration of your disqualification was not received in the time required. The entity must immediately remove you from the position." The letter further indicated, "You cannot have any job where you would provide direct contact services and a DHS background study is required. In a nursing home or boarding care home, you are not permitted to have any job or position." C-F C-F -was hired on June 14, 2024, to provide dining services to the assisted living residents. C-F's pay history report from May 25, 2025, through August 2, 2025, indicated C-F's work hours ranged from 56.93 hours to 64.82 hours every two weeks. C-F's employee record lacked documentation of a cleared background study affiliated with the licensee. The licensee's NetStudy 2.0 employee background study roster printed August 18, 2025, did not include C-F as having a background study affiliated with the licensee. On August 18, 2025, at 12:43 p.m., GM-H stated they were unsure why C-F's background study was not completed. The licensee's undated Employee File policy indicated every employee of [facility name] shall have a personnel file created upon hire. The employee file shall contain verification of the Departments of Health (DHS) background study response.	01290		

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01290	Continued From page 35 Continuous Direct Supervision defined in NETStudy 2.0 System User Manual Updated July 7, 2023, page 7: Continuous, Direct Supervision - An individual is within sight or hearing of the program's supervising individual to the extent that the program's supervising individual is capable at all times of intervening to protect the health and safety of the persons served by the program. Direct Contact Services - Providing face-to-face care, training, supervision, counseling, consultation, or medication assistance to persons served by the entity. Supervision defined in, NETStudy 2.0 System User Manual Updated July 7, 2023, page 53: Supervision Status Study subjects must be under continuous, direct supervision until the study subject is determined eligible of until the entity is notified by DHS that the study subject may provide unsupervised services while the background study is being completed. The supervision status is shown in the "Supervision Required" column for convenience. However, programs are instructed to rely on background study notices for supervision status and other background study determination information. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living	01440		

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01440	Continued From page 36 facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual began working for the licensee for one of one unlicensed personnel (ULP)-D. 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).	01440		

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01440	Continued From page 37 The findings include: ULP-D was hired on November 18, 2022, to provide direct care services to residents of the facility. ULP-D's employee record lacked documented evidence of a supervision of performing delegated tasks within 30 calendar days. On August 18, 2025, at 11:30 a.m., the surveyor observed ULP-D administer R2's noon insulin. On August 20, 2025, at 1:05 p.m., assisted living director in residency/licensed practical nurse (ALDIR/LPN)- A stated ALDIR/LPN-A did not find a supervisory visit in ULP-D's employee file. Clinical nurse supervisor (CNS)-B stated CNS-B was unaware direct supervision of ULPs performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility. In addition, CNS-B stated she had not completed supervisory visits with the new employees since beginning her position as CNS on April 23, 2025. The licensee's 6.17 Supervision of Staff - Delegated Services dated July 21, 2022, indicated direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for [facility name] and first performs the delegated tasks for residents and thereafter as needed based on performance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	01440		

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01440	Continued From page 38 (21) days	01440		
01460 SS=D	144G.63 Subdivision 1 Orientation of staff and supervisors (a) All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility, except as provided in paragraph (b). (b) A staff person is not required to repeat the orientation required under subdivision 2 if the staff person transfers from one licensed assisted living facility to another facility operated by the same licensee or by a licensee affiliated with the same corporate organization as the licensee of the first facility, or to another facility managed by the same entity managing the first facility. The facility to which the staff person transfers must document that the staff person completed the orientation at the prior facility. The facility to which the staff person transfers must nonetheless provide the transferred staff person with supplemental orientation specific to the facility and document that the supplemental orientation was provided. The supplemental orientation must include the types of assisted living services the staff person will be providing, the facility's category of licensure, and the facility's emergency procedures. A staff person cannot transfer to an assisted living facility with dementia care without satisfying the additional training requirements under section 144G.83.	01460		

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	30484	A. BUILDING: _____ B. WING _____	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST CARE FACILITIES DBA AUTUMN HIL	2528 PARK AVENUE NW BEMIDJI, MN 56601

(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
01460	Continued From page 39 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide staff orientation to assisted living licensing requirements and regulations for one of three employees (cook (C)-F). This practice resulted in a level two violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: During the entrance conference on August 18, 2025, at 9:30 a.m., assisted living director in residency/licensed practical nurse (ALDIR/LPN)-A stated the licensee was aware of required content in an employee record. C-F was hired June 14, 2024, to provide indirect care services to the residents of the facility. C-F's employee record lacked documentation to indicate C-F completed orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. On August 20, 2025, at 12:45 p.m., ALDIR/LPN-A stated ALDIR/LPN-A was unable to locate orientation training in C-F's employee file or completed training in Educare (electronic training	01460		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30484	A. BUILDING: _____ B. WING _____	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST CARE FACILITIES DBA AUTUMN HIL	2528 PARK AVENUE NW BEMIDJI, MN 56601

(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
01460	Continued From page 40 program). ALDIR/LPN-A stated the previous clinical nurse supervisor (CNS) had scanned employee records into the employee files and the paper documents were shredded. ALDIR/LPN-A stated most likely the orientation was not completed. The licensee's 4.18 Employee General Orientation policy dated July 21, 2022, indicated upon hire and prior to performing any functions of their position at [facility name], each new employee and volunteer will be orientated in accordance to state and federal regulations, as well as company policy and procedure. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01460		
01550 SS=D	144G.64 (a) (4) Training in Dementia, Mental Illness, and De- (4) staff who do not provide direct care, including maintenance, housekeeping, and food service staff, must have at least four hours of initial training on topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date, and must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; and	01550		

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	30484	A. BUILDING: _____ B. WING _____	08/20/2025

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MIDWEST CARE FACILITIES DBA AUTUMN HIL	2528 PARK AVENUE NW BEMIDJI, MN 56601

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01550	Continued From page 41 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide dementia, mental illness and de-escalation orientation for one of one employee (cook (C)-F). 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) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: During the entrance conference on August 18, 2025, at 9:30 a.m., assisted living director in residency/licensed practical nurse (ALDIR/LPN)-A stated the licensee was aware of required content in an employee record. C-F was hired June 14, 2024, to provide indirect care services to the residents of the facility. C-F's employee record lacked documentation to indicate C-F completed at least four hours of initial dementia training as required within 160 working hours of the employment hire date and two hours of initial mental illness and de-escalation topics due by July 1, 2025. On August 20, 2025, at 12:45 p.m., ALDIR/LPN-A stated ALDIR/LPN-A was unable to locate orientation training or completed training in Educare (electronic training program) in C-F's employee file. ALDIR/LPN-A stated the previous	01550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30484	A. BUILDING: _____ B. WING _____	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST CARE FACILITIES DBA AUTUMN HIL	2528 PARK AVENUE NW BEMIDJI, MN 56601

(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
01550	Continued From page 42 clinical nurse supervisor (CNS) had scanned employee records into the employee files and the paper documents were shredded. ALDIR/LPN-A stated most likely the orientation was not completed. The licensee's 4.18 Employee General Orientation policy dated July 21, 2022, indicated upon hire and prior to performing any functions of their position at [facility name], each new employee and volunteer will be orientated in accordance to state and federal regulations, as well as company policy and procedure. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01550		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained to include an opened date and expiration date for time sensitive medications stored and managed by the licensee for two of two medication carts (Wings one and three cart, Wing two cart). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01880		

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	30484	A. BUILDING: _____ B. WING _____	08/20/2025

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MIDWEST CARE FACILITIES DBA AUTUMN HIL	2528 PARK AVENUE NW BEMIDJI, MN 56601

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01880	Continued From page 43 safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On August 18, 2025, at 10:55 a.m., the surveyor observed the medication carts with clinical nurse supervisor (CNS)-B and observed the following: Wings one and three cart -R2 opened Lantus Solostar (treats high blood sugar)100 units/milliliter (ml) insulin pen lacked open and expiration dates; and -R9's opened Breo Ellipta (treats breathing issues) 200 micrograms (mcg)/25 mcg inhaler lacked open and expiration dates. Wing two cart -R5 opened Lantus Solostar 100 units/ml insulin pen lacked open and expiration dates; and -R7 opened Latanoprost (treats eye pressure) 0.0005% eye drops lacked open and expiration dates. On August 18, 2025, at 11:00 a.m., unlicensed personnel (ULP)-C stated ULPs were expected to label time sensitive medications with open and expiration dates. On August 18, 2025, at 11:25 a.m., CNS-B verified the above medications. CNS-B stated time sensitive medications should be labeled with open and expiration dates. The manufacturer's instructions for Lantus insulin	01880		

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MIDWEST CARE FACILITIES DBA AUTUMN HIL	2528 PARK AVENUE NW BEMIDJI, MN 56601

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01880	Continued From page 44 pen dated June 2022, indicated to discard 28 days after opening even if it still has insulin in it. The manufacturer's instructions for Breo Ellipta inhaler dated November 2024, indicated to discard 6 weeks after the tray is open or when the counter reads "0". The manufacturer's instructions for Latanoprost eye drops dated March 2022, indicated to discard after 4 weeks of opening. A policy was requested, however, was not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
02310 SS=K	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for three of three residents (R9, R8, R10) with an assistive device (consumer bed rails). This practice resulted in a level four violation (a	02310		

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02310	Continued From page 45 violation that harmed a resident's health or safety, not including serious injury or death, or a violation that was likely to lead to serious injury or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly but is not found to be pervasive). This practice resulted in an immediate order for correction on August 19, 2025. The findings include: On August 19, 2025, at 11:25 a.m., clinical nurse supervisor (CNS)-B stated they were not aware consumer-style bed rails needed to be checked for recalls quarterly, and was unsure if the licensee had the manufacturer installation instructions for the consumer bed rails currently installed. CNS-B further stated the consumer bed rails were in place at the facility prior to CNS-B beginning employment in April 2025. R9's diagnosis included major depressive disorder, hypertension (high blood pressure) and borderline personality disorder. R9's service plan dated July 24, 2025, indicated R9 received services including assistance with medication administration, behavior management, lymphedema pumps, dressing, bathing, skin care, toileting, laundry and housekeeping. R8's diagnosis included atrial fibrillation (irregular heart beat), asthma (breathing disorder), and anxiety.	02310		

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02310	Continued From page 46 R8's service plan dated September 21, 2023, indicated R8 received services including assistance with medication management, bathing, dressing, housekeeping and laundry. R10's diagnosis included hypertension, hypothyroidism (underactive thyroid) and dementia. R10's service plan dated July 22, 2025, indicated R10 received services including assistance with medication administration, behavior management, assistance with grooming, laundry and housekeeping. On August 19, 2025, from 11:55 a.m. through 12:05 p.m., the surveyor observed the following with assisted living director in residency/licensed practical nurse (ALDIR/LPN)-A, and CNS-B: -R9's bed included a U-shaped consumer-style bed rail on the upper left side of the bed; -R8's bed included a M-shaped (contour) consumer-style bed rail on right side of bed; and -R10's bed included a M-shaped (contour) consumer-style bed rail on the right side of the bed. RECALLED BED RAIL R9's 90-day assessment dated July 24, 2025, indicated R9 had a side rail on the left side of her bed. R9 used bed rail to assist for assist in transferring. R9 was educated and provided the risks and benefits of bed rails. R9 verbalized understanding. On August 19, 2025, at 12:35 p.m., ALDIR/LPN-A stated they had found R9's consumer bed rail instructions online (computer search) and searched the Consumer Product Safety Website	02310		

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02310	Continued From page 47 (CPSC). The CPSC website, printed August 18, 2025, indicated the Medline device had been recalled since May 30, 2024. The CPSC website further indicated, "When the recalled bed rails are attached to an adult's bed, users can become entrapped within the bed rail or between the bed rail and the side of the mattress. This poses a serious entrapment hazard and risk of death by asphyxiation." LACKING INSTALLATION INSTRUCTIONS/RECALL CHECK R8's 90-day assessment dated May 22, 2025, indicated R8 had a Medpro M grip contour bedrail on right side of bed, secured per manufacturer instructions. The assessment indicated R8 was using the bed rail to assist getting in and out of bed and changing positions. The assessment further indicated R8 was educated and provided the risks and benefits of bed rails, and R8 verbalized understanding. R8's record lacked the consumer bed rail manufacturer installation instructions and lacked evidence the CPSC website had been periodically checked to identify whether the bed rail had been recalled. On August 19, 2025, at 12:10 p.m., CNS-B found R8's consumer bed rail instructions online and also searched the CPSC website, which indicated the consumer bed rail had not been recalled. LACKING RECALL CHECK R10's 90-day assessment dated July 22, 2025, indicated R10 had a partial side rail, and indicated it was installed per manufacturer	02310		

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02310	Continued From page 48 instructions. The assessment further indicated R10 used bed rail to assist in turning and repositioning, and that R10 was educated and notified of the risks and benefits of using bed rails. The assessment indicated R10 verbalized understanding. R10's record lacked evidence of manufacturer installation instructions, and evidence the CPSC website was periodically checked for recall of the bed rail. On August 19, 2025, at 12:15 p.m., ALDIR/LPN-A stated they found R10's consumer bedrail manufacturer instructions in his electronic chart, however, could not find documentation the bed rail was checked for recalls. ALDIR/LPN-A stated they had now checked the CPSC website, and it indicated the consumer bed rail had not been recalled as of that date. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail;	02310		

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02310	Continued From page 49 - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. The FDA, "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients." The FDA also identified, "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Bemidji District Office
Minnesota Department of Health
705 5th St NW, Suite A
Bemidji, MN 56601
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

AUTUMN HILLS ASSISTED LIVING
2528 PARK AVENUE NW
Bemidji, MN 56601
Beltrami County
Parcel:

Phone:

License Info

License: HFID 30484

Risk:
License:
Expires on:
CFPM: Alisha Kohler
CFPM #: 113796; Exp: 11/11/2025

Inspection Info

Report Number: F3822251049
Inspection Type: Full - Single
Date: 8/19/2025 Time: 11:30:26 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 1
Total Priority 3 Orders: 3
Delivery:

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: PROVIDE AND USE 160F TEST STRIPS FOR THE DISHWASHER.
Comply By: 8/26/2025 Originally Issued On: 8/19/2025

New Order: 4-600 Cleaning Equipment and Utensils
4-602.12 *Priority Level: Priority 3 CFP#: 16*
MN Rule 4626.0850 Clean the food contact surfaces of cooking and baking equipment and interior cavities of microwave ovens at least every 24 hours.
COMMENT:
Comply By: Complied On Site Originally Issued On: 8/19/2025

New Order: 6-200 Physical Facility Design and Construction
6-201.13A *Priority Level: Priority 3 CFP#: 55*
MN Rule 4626.1345A Properly cove and seal the wall/floor junctures to no larger than 1/32 inch (1 millimeter).
COMMENT: FINISH INSTALLING WALL COVING BEHIND COFFEE STATION IN DINING ROOM.
Comply By: 9/23/2025 Originally Issued On: 8/19/2025

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control
6-501.14A *Priority Level: Priority 3 CFP#: 56*
MN Rule 4626.1530A Maintain clean all intake and exhaust air ducts and change filters so they are not a source of contamination.
COMMENT: OBSERVED KITCHEN CEILING VENTS WITH ACCUMULATION OF DUST.
Comply By: 8/21/2025 Originally Issued On: 8/19/2025

Food & Beverage General Comment

COORDINATED INSPECTION WITH HRD. NO FOLLOW UP REQUIRED.

VERIFY HOT WATER SANITIZING DISHWASHER CONTINUES FUNCTIONING PROPERLY BY TESTING TEMPERATURE REGULARLY.

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 F3822251049 from 8/19/2025

Alisha Kohler
Head Cook

Dave Kaufman,
Public Health Sanitarian 3
218-308-2113
david.kaufman@state.mn.us

Bemidji District Office
Minnesota Department of Health
705 5th St NW, Suite A
Bemidji, MN 56601

Temperature Observations/Recordings

Establishment Info

AUTUMN HILLS ASSISTED LIVING
Bemidji
County/Group: Beltrami County

Inspection Info

Report Number: F3822251049
Inspection Type: Full
Date: 8/19/2025
Time: 11:30:26 AM

Food Temperature: Product/Item/Unit: ; Temperature Process: Cold-Holding
Location: Walk-in Cooler at 41 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: ; Temperature Process: Cold-Holding
Location: Upright Cooler at 41 Degrees F.
Comment: LEFTOVER CHICKEN PASTA FROM YESTERDAY.
Violation Issued?: No

Bemidji District Office
Minnesota Department of Health
705 5th St NW, Suite A
Bemidji, MN 56601

Sanitizer Observations/Recordings

Establishment Info

AUTUMN HILLS ASSISTED LIVING
Bemidji
County/Group: Beltrami County

Inspection Info

Report Number: F3822251049
Inspection Type: Full
Date: 8/19/2025
Time: 11:30:26 AM

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

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** 3-Compartment Sink
Location: Equal To 400 PPM
Comment:
Violation Issued?: No

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

Minnesota (MDH) Version
EH Manager; RPT: F3822251049

Food Establishment Inspection Report

Bemidji District Office
Minnesota Department of Health
705 5th St NW, Suite A
Bemidji, MN 56601

No. of Risk Factor/Intervention/Violations	1	Date: 8/19/2025
No. of Repeat Risk Factor/Intervention/Violations		Time: 11:30:26 AM
Score (optional)		Dur: min

Establishment:	Address:	City/State:	Zip:	Phone:
AUTUMN HILLS ASSISTED LIVING	2528 PARK AVENUE NW	Bemidji, MN	56601	
License/Permit #:	**Permit Holder:**	**Purpose of Inspection:**	**Est. Type:**	**Risk Category:**
HFID 30484		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Designated compliance status (IN, OUT, N/O, N/A) for each numbered item

IN=in compliance **OUT**=not in compliance **N/O**=not observed **N/A**=not applicable

Mark "X" in appropriate box for COS and/or R

COS=corrected on-site during inspection **R**=repeat violation

	Compliance Status		COS	R
	Supervision			
1	IN	Person in charge present, demonstrate knowledge and performs duties		
2	IN	Certified Food Protection Manager		
	Employee Health			
3	IN	knowledge, responsibiities, and reporting		
4	IN	Proper use of restriction and exclusion		
5	IN	Response to vomiting, diarrheal events		
	Good Hygienic Practices			
6	IN	Proper eating, tasting, drinking, tobacco use		
7	IN	No discharge from eyes, nose, and mouth		
	Preventing Contamination by Hands			
8	N/O	Hands clean and properly washed		
9	N/O	No bare hand contact with RTE foods, alternatives		
10	IN	Adequate handwashing sinks supplied and access		
	Approved Source			
11	IN	Food obtained from approved source		
12	N/O	Food Received at proper temperature		
13	IN	Food in good condition, safe & unadulterated		
14	N/A	Records available: shellstock tags, parasite dest.		
	Protection From Contamination			
15	IN	Food separated and protected		
16	OUT	Food-contact surfaces; cleaned & sanitized	X	
17	IN	Proper Disposition of returned, previously served, reconditioned,& unsafe food		

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

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

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" or OUT in box if numbered item is **not** in compliance Mark "X" in appropriate box for COS and/or R **COS**=corrected on-site during inspection **R**=repeat violation

			COS	R
		Safe Food and Water		
30	IN	Pasteurized eggs used where required		
31		Water & ice from approved source		
32	N/A	Variance obtained for specialized processing methods		
		Food Temperature Control		
33		Proper cooling methods used; adequate equipment for temperature control		
34	N/O	Plant food properly cooked for hot holding		
35	N/O	Approved thawing methods used		
36		Thermometers provided & accurate		
		Food Identification		
37		Food properly labeled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present; no unauthorized person		
39		Contamination prevented during food prep, storage, & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
		Proper Use of Utensils		
43		In-use utensils; Properly stored		
44		Utensils, equipment & linens; properly stored, dried, handled		
45		Single-use & single-service articles, properly stored and used		
46		Gloves used properly		
		Utensils, Equipment and Vending		
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48	X	Warewashing facilities: installed, maintained, used; test strips		
49		Non-food contact surfaces clean		
		Physical Facilities		
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities; properly constructed, supplied & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55	X	Physical facilities installed, maintained & clean		
56	X	Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing and plan review		

Person in Charge (signature)

Inspector (signature) Dave Kaufman

Follow-up: Follow-up Date: