Electronically Delivered

May 22, 2026

Licensee
Medford Senior Care
108 3rd Street Northeast
Medford, MN 55049

RE: Project Number(s) SL29746017

Dear Licensee:

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

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00

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

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders 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,

Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29746	A. BUILDING: _____ B. WING _____	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDFORD SENIOR CARE	108 3RD STREET NE MEDFORD, MN 55049

(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: SL29746017-0 On April 27, 2026, through April 29, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 23 residents; 21 receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated April 28, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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0 480	Continued From page 3 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complies with accepted health care, medical and nursing standards for infection control related to glove use and handwashing during AM cares by two of two unlicensed personnel (ULP-E, ULP-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, 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	0 510		

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0 510	Continued From page 4 portion or all of the residents). The findings include: R1's service plan effective February 26, 2026, indicated the resident received services to include dressing, grooming, bathing, toileting/incontinence care, two-person transfers, wheelchair mobility, oxygen, compression garment, lymphedema pump, housekeeping, laundry, and medication administration. On April 28, 2026, at 10:16 a.m., the surveyor observed unlicensed personnel (ULP)-E and ULP-F providing AM cares for R1. ULP-E and ULP-F cleansed hands and donned gloves prior to assisting R1, who was seated in her recliner where she had slept. The ULPs positioned a lift sling underneath/behind R1 and then proceeded to attach the sling to a Hoyer lift. Once attached, ULP-E manually cranked the Hoyer lift to raise R1 out of the recliner; ULPs then transferred R1 to her bed to remove her soiled brief and provide pericare. ULP-E obtained a wet soapy washcloth from the bathroom while ULP-F remained with R1. ULP-E returned to R1 and provided pericare, returned to the bathroom for another wet washcloth, then returned to R1 and rinsed and dried the peri-area. ULP-E then returned to the bathroom, obtained a wet washcloth, and repeated the process on R1's bottom while ULP-F assisted R1 to roll onto her side. When finished, while wearing the same gloves, ULP-E assisted ULP-F with transferring R1 into the bathroom via the Hoyer lift. Once R1 was positioned and lowered safely onto the toilet, ULP-E and ULP-F advised R1 to utilize her call pendant to let them know when she was finished. ULP-E and ULP-F doffed their gloves and exited the bathroom. Upon exiting the bathroom, ULP-F	0 510		

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0 510	Continued From page 5 walked over to R1's kitchenette area and utilized hand sanitizer from a bottle on the counter to cleanse her hands, and proceeded to make R1's bed. ULP-E obtained new oxygen tubing for R1's oxygen concentrator and then proceeded to switch out the tubing. Once tasks were completed, the ULPs stated they would leave and return once R1 pushed her pendant for assistance. ULP-E and ULP-F then exited the apartment; ULP-E had still not washed her hands or utilized hand sanitizer. About halfway down the hall, ULP-E then utilized hand sanitizer that was mounted on the wall. The surveyor asked her when she would sanitize her hands when assisting residents. ULP-E stated when she entered the room and when she was finished performing cares. On April 28, 2026, at 1:02 p.m., clinical nurse supervisor (CNS)-C stated hand hygiene should be performed before and after resident cares and after removal of gloves. CNS-C further stated gloves should be changed after providing pericare. The licensee's 8.09 Hand Washing policy dated December 30, 2022, indicated: Proper hand washing techniques should be used to protect the spread of infection. Hand washing shall be completed: After changing incontinence products or cleaning up after someone who has used the toilet. Hand Hygiene and Gloves When conducting a procedure requiring the use of gloves, proper hand hygiene should be completed before donning gloves and after removing gloves. No further information provided.	0 510		

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0 510	Continued From page 6 TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's diagnoses included hypertension (high blood	0 630		

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0 630	Continued From page 7 pressure), asthma, chronic pain, and weakness. R2's service plan effective October 10, 2025, indicated R2 received assistance with grooming, bathing, toileting, transfers, compression stockings, housekeeping, laundry, and medication administration. R2's Individual Abuse Prevention Plan (IAPP) dated April 3, 2026, failed to include: -the person's risk of abusing other vulnerable adults. On April 28, 2026, at 1:02 p.m., clinical nurse supervisor (CNS)-B reviewed R2's IAPP and stated it did not included the above required content. The licensee's 6.05 Individual Abuse Prevention Plan policy dated December 30, 2022, indicated: 1. The plan will contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including: a. other vulnerable adults b. the person's risk of abusing other vulnerable adults, and c. statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following	0 680		

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0 680	Continued From page 8 requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness (EP) plan with the required content. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that	0 680		

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0 680	Continued From page 9 has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's Emergency Preparedness Manual lacked the following required content: - Emergency prep testing requirements On August 29, 2026, at 10:40 a.m., administrative assistant (AA)-B stated they had conducted a missing resident drill and also had an actual event occur when an active shooter was in the area last summer. AA-B was unable to locate documentation related to the missing resident drill or actual event. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 775		

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0 775	Continued From page 10 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated April 29 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan	01640		

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01640	Continued From page 11 must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a written service plan was revised to reflect the current services provided for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's diagnoses included hypertension (high blood pressure), asthma, chronic pain, and weakness. On April 27, 2026, at 2:25 p.m., the surveyor observed R2 seated in a wheelchair in the R2's apartment. The surveyor observed a large Band-Aid on each of R2's forearms near the elbow. R2 stated he had fallen recently when transferring with staff. R2's progress note dated April 22, 2026, at 2:57 p.m., indicated R2 had a witnessed fall while working with physical therapy. R2 sustained skin tears to bilateral elbows and bruising to left arm. Wound care was provided.	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29746	A. BUILDING: _____ B. WING _____	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDFORD SENIOR CARE	108 3RD STREET NE MEDFORD, MN 55049

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01640	Continued From page 12 R2's record included the following provider order dated April 23, 2026: - OK for wound care to elbows. Cleanse skin tears with gauze and wound cleanser. Apply petroleum gauze. Cover with border foam dressing. Change 2-3 x/week and PRN (as needed) if dressing missing or soiled. DC (discontinue) order when healed. R2's Service Recap Summary dated April 2026, included: - Wound care - RN (registered nurse) R2's service plan effective October 10, 2025, indicated R2 received assistance with grooming, bathing, toileting, transfers, compression stockings, housekeeping, laundry, and medication administration. R2's service plan did not include the wound care service to R2's elbows. On April 28, 2026, at 1:02 p.m., clinical nurse supervisor (CNS)-C stated R2's wound care was considered an "unscheduled service" and not added to the service plan. CNS-C further stated R2's wound care wasn't scheduled on certain days as the service would depend upon if the dressing had loosened and needed more frequent changing. The licensee's 6.08 Service Plan policy dated December 20, 2022, indicated: 3. Services plans shall be revised, if needed, based on resident reassessments and monitoring. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01640	Continued From page 13 (21) days	01640		
01690 SS=F	144G.71 Subdivision 1 Medication management services (a) This section applies only to assisted living facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23. This MN Requirement is not met as evidenced	01690		

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	29746	A. BUILDING: _____ B. WING _____	04/29/2026

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01690	Continued From page 14 by: Based on interview and record review, the licensee failed to follow licensee's policy regarding destruction of schedule II-V controlled medications. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's 7.23 Medication Disposal policy dated December 30, 2022, indicated: Unused Controlled Substances: - Current unused controlled substances remaining when the resident's medications are no longer managed by [Licensee name], the medications are expired, or the medication has been discontinued by the prescriber, must be disposed of in accordance with accepted practices of the Minnesota Board of Pharmacy. - Upon disposition, the facility must document in the residents' record the disposition of the expired medication including the medication's name, strength, prescription number as applicable, quantity, date of disposition, and names of staff (including a witness) and other individuals involved in the disposition. Disposal of all narcotics will be conducted in the presence of two licensed staff of [Licensee name]. Licensed staff may consist of RN (registered nurse), LP (licensed practical nurse) and/or LALD (licensed assisted living director).	01690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29746	A. BUILDING: _____ B. WING _____	04/29/2026

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MEDFORD SENIOR CARE	108 3RD STREET NE MEDFORD, MN 55049

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01690	Continued From page 15 - Medication will then be placed in a locked cupboard in locked management office. Upon disposal of medications, medications will be packaged in secured box. Box will be signed out to be transported by LALD-A or owner (O)-H to off site medication drop off box for disposition. - A hard copy of the destruction record will be kept on file at the facility for two (2) years. Destruction of narcotics will also be documented and co-signed by licensed staff in Residex/Rtasks electronic resident record. The licensee's Certificate of the Inventory and Destruction of Controlled Substances Form, indicated the following: We, the undersigned, certify that we have inventoried the following Schedule II thru V Controlled Substance, which are excess or obsolete stock and that they have been destroyed in our presence on this date. The form included hand-written documentation of each medication, including prescription number, strength, quantity, and date destroyed, from September 25, 2025, thru February 11, 2026. Each medication was signed off by clinical nurse supervisor (CNS)-C and either LALD/licensed practical nurse (LALD/LPN)-A or owner (O)-H. There were 11 different dates of destruction on the form. Four of the 11 dates were co-signed by LALD/LPN-A; seven of the 11 dates were co-signed by O-H. On April 29, 2026, at 11:45 a.m., CNS-C stated controlled substances are reconciled and counted with two nurses, then kept double locked until one of the owners (LALD/LPN-A or O-H) retrieves the medications for destruction. CNS-C then releases the controlled substances to the owner, who then takes them to the police station for destruction; CNS-C does not accompany the owner to the police station with the medications.	01690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01690	Continued From page 16 CNS-C stated once the owner leaves with the medications, he is unsure if the owner obtained verification from the police station that the medications had been received for destruction as has no documentation to back this up. The actual destruction of the medications was not witnessed by two licensed staff as per indicated on the licensee's policy. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01690		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01950	Continued From page 17 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of two unlicensed personnel (ULP-E, ULP-F) demonstrated competency in compression stockings, Velcro wraps and compression pumps to a registered nurse (RN). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on April 27, 2026, at 10:48 a.m., clinical nurse supervisor (CNS)-C stated the licensee provided treatment management services to the licensee's residents. R1's service plan effective February 26, 2026, included assistance with compression garment and lymphedema pump. ULP-E ULP-E was hired March 13, 2024, to provide direct care services. On April 28, 2026, at 10:34 a.m., the surveyor observed ULP-E applying compression stockings to R1's lower legs bilaterally, and a Velcro compression wrap to R1's right lower leg. ULP-F	01950		

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01950	Continued From page 18 ULP-F was hired June 20, 2025, to provide direct care services. ULP-E and ULP-F's employee record lacked competencies for compression stockings, Velcro compression wraps and compression leg pumps. On April 29, 2026, at 9:13 a.m., clinical nurse supervisor (CNS)-C stated he was unable to find evidence in ULP-E or ULP-F's employee record of competency training/testing by an RN for compression stockings, compression Velcro wraps and compression leg pumps. The licensee's 6.14 Delegation of Assisted Living Services policy dated December 30, 2022, indicated: 4. A RN may delegate nursing services to a person who has successfully completed staff orientation, who has been trained in the service to be provided, and who has demonstrated to the RN the ability to competently follow the procedures for the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		

Rochester District Office
Minnesota Department of Health
3425 40th Ave NW, Suite 115
Rochester, MN 55901
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Medford Senior Care LLC
108 3RD STREET NE
Fridley, MN 55049
Anoka County
Parcel:

Phone:

License Info

License: HFID 29746

Risk:
License:
Expires on:
CFPM: Stephanie J. Almendinger
CFPM #: 88918; Exp: 05/03/2026

Inspection Info

Report Number: F8044261128
Inspection Type: Full - Single
Date: 4/28/2026 Time: 8:14:36 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 1
Total Priority 3 Orders: 1
Delivery: Emailed

New Order: 3-500A Microbial Control: cooling
3-501.13E *Priority Level: Priority 3 CFP#: 35*
MN Rule 4626.0380E Remove frozen fish from the reduced oxygen package prior to thawing under refrigeration or immediately after thawing if using the running water method of thawing.
COMMENT: Frozen fished thawed in sealed vacuum packaging.
Comply By: 4/28/2026 Originally Issued On: 4/28/2026

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: Unable to locate quaternary ammonium test kit.
Comply By: 4/28/2026 Originally Issued On: 4/28/2026

Food & Beverage General Comment

HRD inspection conducted with nurse evaluator Wendy Buckholz. Inspection report reviewed on site with Kathy.

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 Rochester District Office inspection report number F8044261128 from 4/28/2026

Kathy

Michael DeMars, RS
Public Health Sanitarian 3
michael.demars@state.mn.us

Rochester District Office
Minnesota Department of Health
3425 40th Ave NW, Suite 115
Rochester, MN 55901

Temperature Observations/Recordings

Establishment Info

Medford Senior Care LLC
Fridley
County/Group: Anoka County

Inspection Info

Report Number: F8044261128
Inspection Type: Full
Date: 4/28/2026
Time: 8:14:36 AM

Food Temperature: Product/Item/Unit: Milk**; Temperature Process:** Cold-Holding
Location: Upright Cooler 1 at 38.1 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: ; Temperature Process: Cold-Holding
Location: Upright Cooler 1 at 34.0 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Tuna salad**; Temperature Process:** Cold-Holding
Location: Upright Cooler 2 at 37.8 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: ; Temperature Process: Cold-Holding
Location: Upright Cooler 2 at 39.0 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Sausage patties**; Temperature Process:** Re-Heating (commercial)
Location: Oven at 178.3 Degrees F.
Comment:
Violation Issued?: No

Rochester District Office
Minnesota Department of Health
3425 40th Ave NW, Suite 115
Rochester, MN 55901

Sanitizer Observations/Recordings

Establishment Info

Medford Senior Care LLC
Fridley
County/Group: Anoka County

Inspection Info

Report Number: F8044261128
Inspection Type: Full
Date: 4/28/2026
Time: 8:14:36 AM

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** Dispenser
Location: Kitchen **Equal To** 400 PPM
Comment:
Violation Issued?: No

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Kitchen **Equal To** 163.5 Degrees F.
Comment:
Violation Issued?: No

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL29746017-0	**Date:** 4/29/2026
Facility Name: Medford Senior Care LLC	
Facility Address: 108 3rd St NE Medford, Mn, 55409	

☒ **TAG IDENTIFICATION: 0775**

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

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

2. Exit signs shall be illuminated at all times. To ensure continued illumination for a duration of not less than 90 minutes in case of primary power loss, the sign illumination means shall be connected to an emergency power system provided from storage batteries, unit equipment or an on-site generator. [Minn. Stat. 144G.45 subd. 2; MSFC 1013.6.3]

   Comments: At the time of survey, near unit H the exit light battery backup would not function.

3. The emergency power system for means of egress illumination shall provide power for not less than 30 minutes and consist of storage batteries, unit equipment, or an on-site generator. [Minn. Stat. 144G.45 subd. 2; MSFC 1104.5.3]

   Comments: At the time of survey, near unit F the emergency light would not function.

4. Fire detection and alarm systems, emergency alarm systems, gas detection systems, fire-extinguishing systems, mechanical smoke exhaust systems and smoke and heat vents shall be maintained in an operative condition at all times and shall be replaced or repaired where defective. [Minn. Stat. 144G.45 subd. 2; MSFC 901.6]

   Comments: At the time of survey, the kitchen Ansul system was red tagged for noncompliance due to 12 year hydrostatic testing required.