Electronically Delivered

July 30, 2026

Licensee
Millstream Commons
210 West 8th Street
Northfield, MN 55057

RE: Project Number(s) SL30490017

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 8, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

pursuant to this survey:

0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00
0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - $500.00
1290 - 144g.60 Subdivision 1 - Background Studies Required - $1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $2,000.00**. 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.

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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30490	A. BUILDING: _____ B. WING _____	07/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLSTREAM COMMONS	210 WEST 8TH STREET NORTHFIELD, MN 55057

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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: SL30490017-0 On July 6, 2026, through July 8, 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 47 residents; 31 receiving services under the Assisted Living Facility license. 1290: An immediate order was issued on July 7, 2026, at a level 3/Widespread (I). The licensee took immediate action; however, the scope and level remain at I.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 630 SS=E	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma	0 630		

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0 630	Continued From page 1 (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 observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for three of three residents (R1, R2, and 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1 was admitted on July 1, 2024, with diagnoses that included high blood pressure. On July 7, 2026, at 8:49 a.m., the surveyor observed unlicensed personnel (ULP)-E	0 630		

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0 630	Continued From page 2 administer medications to R1. R1's service plan dated February 23, 2026, indicated R1 received services to include dressing, mobility/ambulation, thrombo-embolic deterrent (TED) stockings (stockings designed to prevent blood clots and swelling in legs) and medication administration. R1's IAPP Form dated May 22, 2026, indicated R1 was not susceptible to abuse from another individual, including other vulnerable adults. The licensee failed to recognize R1 was a vulnerable adult and was susceptible to abuse/neglect by others. Furthermore, the licensee failed to implement interventions to minimize abuse by others including other vulnerable adults. R2 R2 was admitted on September 30, 2025, with diagnoses that included diabetes. On July 7, 2026, at 7:27 a.m., the surveyor observed ULP-E check R2's blood sugar. R2's service plan dated March 3, 2026, indicated R2 received services to include medication administration and blood glucose monitoring. R2's IAPP Form dated April 14, 2026, indicated R2 was not susceptible to abuse from another individual, including other vulnerable adults. The licensee failed to recognize R2 was a vulnerable adult and was susceptible to abuse/neglect by others. Furthermore, the licensee failed to implement interventions to minimize abuse by others including other vulnerable adults. R3 R3 was admitted on June 4, 2024, with diagnoses	0 630		

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0 630	Continued From page 3 that included diabetes. On July 7, 2026, at 12:17 p.m., the surveyor observed ULP-E administer medications to R3. R3's service plan dated April 15, 2026, indicated R3 received services to include dressing, toileting, showers, mobility/ambulation, compression stockings, glucose monitoring, medication administration. R3's IAPP Form dated June 9, 2026, indicated R3 was not susceptible to abuse from another individual, including other vulnerable adults. The licensee failed to recognize R3 was a vulnerable adult and was susceptible to abuse/neglect by others. Furthermore, the licensee failed to implement interventions to minimize abuse by others including other vulnerable adults. On July 8, 2026, at 11:12 a.m., clinical nurse supervisor (CNS)-C reviewed R1, R2, and R3's IAPP and stated it did not indicate that they were at risk of being abused by others. The licensee's Maltreatment Prohibition policy dated August 1, 2021, indicated all residents are considered vulnerable adults and the staff would assess each resident for vulnerability, create and implement and individualized abuse prevent plan to prevent harm. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record	0 730		

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0 730	Continued From page 4 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 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	0 730		

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0 730	Continued From page 5 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 by: Based on interview and record review, the licensee failed to ensure one of one discharged resident's record (R4) included a discharge summary with the required content as required according to MN Rules 4659.0120, Subp. 9. 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: R4 was admitted to the licensee on April 28, 2025, and discharged on January 19, 2026. R4's discharge summary dated January 19, 2026, failed to include: - a summary of the resident's stay that includes allergies, treatments and therapies, and pertinent lab, radiology, and consultation results; - a final summary of the resident's status from the latest assessment or review under Minnesota Statues, section 144G.70, if applicable, that includes the resident status, including baseline and current mental, behavioral, and functional	0 730		

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0 730	Continued From page 6 status; - reconciliation of all predischarge medications with the resident's postdischarge prescribed and over-the-counter medications; and - postdischarge plan that is developed with the resident and, with the resident's consent, the resident's representatives, which will help the resident adjust to a new living environment. The postdischarge plan must indicate where the resident plans to reside, any arrangements that have been made for the resident's follow-up care, and any postdischarge medication and nonmedical services the resident will need. On July 8, 2026, at 11:15 a.m., clinical nurse supervisor (CNS)-C reviewed R4's discharge summary and stated it did not include the content as listed above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
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.	0 775		

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0 775	Continued From page 7 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated July 8, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive	0 810		

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0 810	Continued From page 8 training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical	0 810		

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0 810	Continued From page 9 Environment Inspection Report (PEIR) dated July 8, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	0 810		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license for two of two employees (licensed practical nurse (LPN)-K and unlicensed personnel (ULP)-L). This had the potential to affect all residents residing in the facility. This resulted in an immediate order on July 7, 2026.	01290		

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01290	Continued From page 10 In addition, the licensee failed to ensure background studies were affiliated with the correct health facility identification (HFID) for one of one employee (ULP-M). This practice resulted in a level three violation (a violation that harmed a client/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 the potential to affect a large portion or all the residents). The findings include: On July 7, 2026, at 7:30 a.m., the surveyor reviewed the licensee's NETStudy 2.0 (web-based system used to submit background study requests) roster. The surveyor did not observe LPN-K, ULP-L or ULP-M on the licensee's roster for HFID 30490. At this time, the surveyor requested the licensed assisted living director (LALD)-A to review LPN-K, ULP-L and ULP-M's employee files for a background study clearance letter. On July 7, 2026, at 8:03 a.m., LALD-A replied to the surveyor's request via email and confirmed LPN-K, ULP-L and ULP-M were not included in the licensee's NETstudy roster and questioned if LPN-K needed to be included due to the new requirement that licensed professionals do not have to be cleared on NETstudy. LALD-A stated she requested LPN-K and ULP-L's background study documents from the Human Resources (HR) department. LPN-K	01290		

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01290	Continued From page 11 LPN-K was hired on June 5, 2025, to provide direct care and services to the facility's residents. On July 7, 2026, at 8:12 a.m., a review of the Minnesota Board of Nursing verification website showed that LPN-K was issued an LPN license on July 9, 2015. On July 7, 2026, at 8:26 a.m., a review of NETStudy showed that LPN-K had been affiliated with the assisted living facility HFID 30490; however, was separated from the facility on July 15, 2025. On July 7, 2026, at 8:38 a.m., the surveyor and the LALD reviewed the NETStudy website that indicated LPN-K was separated from the licensee on July 15, 2025. LALD-A stated she was unsure why the HR department would separate LPN-K from the licensee. LALD-A stated LPN-K continued to worked independently providing direct care to the residents as a causal employee for the licensee. On July 11, 2026, at 11:22 a.m., LALD-A provided the surveyor with a background clearance letter for LPN-K dated May 29, 2025. LPN-K's record lacked evidence to indicate the licensee had submitted a background study after LPN-K was separated from the licensee on July 15, 2025. LALD-A stated LPN-K was taken off the schedule until LPN-K completed the background study and was re-affiliated with the licensee. ULP-L ULP-L was hired on November 26, 2025, to provide direct care and services to the facility's residents. On July 11, 2026, at 10:35 a.m., a review of	01290		

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01290	Continued From page 12 NETStudy showed that ULP-L was separated from the licensee on December 15, 2025, and no fingerprints were completed. On July 11, 2026, at 11: 25 a.m., LALD-A stated HR reported that a background study was submitted for ULP-L; however, ULP-L did not complete the fingerprint requirements. LALD-A stated ULP-L worked independently providing direct care to the residents. LALD-A stated ULP-L was a casual employee and was removed from the schedule until ULP-L completed the background study requirements. ULP-M ULP-M was hired on June 22, 2026, to provide direct care and services to the facility's residents. ULP-M's employee record contained Background Study Clearance dated June 17, 2026, from a sister facility. However, the document was not affiliated with the facility's license. On July 11, 2026, at 11:30 a.m., LALD-A stated ULP-M worked independently providing direct care to the residents. LALD-A stated ULP-M's background study was not affiliated with the licensee's HFID. The licensee's Individual Eligibility Screening policy dated April 6, 2020, indicated a background study on an individual after a conditional offer of engagement has been made and before an individual provides direct contact services to individuals receiving services. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290		

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01290	Continued From page 13 The licensee took action on July 7, 2026, to mitigate immediate risk to residents; however, the scope and level remains at l.	01290		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct	01500		

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01500	Continued From page 14 support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of two employees (unlicensed personnel (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 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).	01500		

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01500	Continued From page 15 The findings include: ULP-F was hired on May 29, 2025, to provide direct care and services to the facility's residents. On July 7, 2026, at 8:49 a.m., the surveyor observed ULP-F administer medications to R1. ULP-F's employee record lacked evidence the employee had successfully completed annual training as required, to include the following: -review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases On July 8, 2026, at 11:42 a.m., quality consultant (QC)-G reviewed ULP-F's employee record and stated it lacked evidence of annual infection control training. The licensee's Orientation and Annual Training policy dated August 1, 2021, indicated all staff that perform direct-care services will complete at least eight hours of annual training for each 12 months of employment. The annual training will include review of infection control techniques used in the home and implementation of infection control standards. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One	01500		

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01500	Continued From page 16 (21) days	01500		
01700 SS=D	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one resident (R2) who self-administered medications was assessed for self-administration of	01700		

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01700	Continued From page 17 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 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 was admitted on September 30, 2025, with diagnoses that included diabetes. On July 6, 2026, at 11:01 a.m., the surveyor observed unlicensed personnel (ULP)-F administer R2's medications. At this time, the surveyor observed two bottles of Tylenol, two bottles of diabetic tussin and two bottles of vitamin supplements on R2's white shelves in her living room. The surveyor inquired if R2 self-administered these medications to which R2 stated she did and that the staff was aware of these medications. R2's service plan dated March 3, 2026, indicated R2 received services to include medication administration and blood glucose monitoring. R2's comprehensive nurse assessment dated April 10, 2026, the Medication Management section indicates "facility to manage medication admin and storage". R2's Individualized Medication Management Plan dated March 3, 2026, indicates the following: -RA (resident assistant (unlicensed personnel)) to	01700		

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01700	Continued From page 18 administer medications per eMAR (electronic medication administration record) as delegated by RN and ordered by provider. -staff will provide medication reminders/administration 2-3 times per day On July 8, 2026, at 11:27 a.m., clinical nurse supervisor (CNS)-C stated R2's record did not contain a self-administration of medication assessment because she was not aware that R2 had medications in her apartment that she self-administered. CNS-C stated she expected the ULP to notify her if they observe any medications in a resident's room so the nurse could assess for safety of self-administration. CNS-C stated she would meet with R2 and discuss which medications R2 self-administered and would update R2's record if R2 was found safe to self-administer certain medications. The licensee's Medication Management Services policy dated August 1, 2021, indicated medication management services would be reviewed at least every 90 days or when the resident presents with symptoms or other issues that may be medication related. The medication management record would be current and updated when there were any changes. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse,	01730		

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01730	Continued From page 19 advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing	01730		

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01730	Continued From page 20 medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized medication management plan with the required content for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on July 6, 2026, at approximately 9:45 a.m., clinical nurse supervisor (CNS)-C stated the licensee provided medication management services to their residents at the facility. CNS-C stated medications were stored in medication carts and medications requiring refrigeration were stored in a locked refrigerator in the copy room. R2 was admitted on September 30, 2025, with diagnoses that included diabetes. On July 6, 2026, at 11:01 a.m., the surveyor observed unlicensed personnel (ULP)-F administer R2's medications. At this time, the surveyor observed two bottles of Tylenol, two bottles of diabetic tussin and two bottles of	01730		

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01730	Continued From page 21 vitamin supplements on R2's white shelves in her living room. The surveyor inquired if R2 self-administered these medications to which R2 stated she did and that the staff was aware of these medications. R2's service plan dated March 3, 2026, indicated R2 received services to include medication administration and blood glucose monitoring. R2's comprehensive nurse assessment dated April 10, 2026, the Medication Management section indicates "facility to manage medication admin and storage". R2's Individualized Medication Management Plan dated March 3, 2026, indicates the following: -RA (resident assistant (unlicensed personnel)) to administer medications per eMAR (electronic medication administration record) as delegated by RN and ordered by provider. -staff will provide medication reminders/administration 2-3 times per day -Medication Storage: medications are stored in medication carts. Only staff administering medications each shift will have access to the cart keys. -Insulin Storage: insulin is stored in locked medication with additional insulin stored in locked fridge in the copy room. On July 8, 2026, at 11:27 a.m., CNS-C stated R2's medication management plan did not include self-administration of medications and storage of medications in R2's apartment. CNS-C stated she would assess R2 for appropriateness of self-administration of medications and if R2 was able to self-administer some medications safely, she would update R2's medication plan to reflect this and the ability to store those	01730		

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01730	Continued From page 22 mediations in R2's apartment. The licensee's Individualized Medication, Treatment and Therapy Management policy dated May 17, 2022, indicated the licensee would develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: a. A statement describing the medication, treatment and therapy management services that will be provided; b. A description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; c. Documentation of specific resident instructions relating to the administration of medications, treatment and therapy services; d. Identification of persons responsible for monitoring medication, treatment and therapy supplies and ensuring that refills are ordered on a timely basis; e. Identification of medication, treatment and therapy management tasks that may be delegated to unlicensed personnel; f. Procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication, treatment and therapy management services; and Any resident-specific requirements relating to documenting medication, treatment and therapy administration, verifications that all medications, treatments and therapy services are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. No further information was provided.	01730		

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01730	Continued From page 23 TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medication administration was documented accurately for one of three residents (R1). 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:	01760		

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01760	Continued From page 24 R1 was admitted on July 1, 2024, with diagnoses that included high blood pressure. R1's service plan dated February 23, 2026, indicated R1 received services to include medication administration. R2's signed prescriber orders dated February 24, 2026, included the following: -Benefiber Oral Powder 3 grams; Mix 9 grams in liquid then take by mouth once a day On July 7, 2026, at 8:49 a.m., the surveyor observed unlicensed personnel (ULP)-F administer medications to R1 which included Benefiber powder mixed in water. At this time, R1 asked if she had to drink all of the water with Benefiber in it. ULP-F told R1 that she didn't have to drink it all at once and could sip on it. R1 took her medications, drank one-fourth of the water with Benefiber in it and then set it on her side table. While ULP-F was in R1's apartment, R1 repeatedly asked ULP-F when she could go home, why she was here and what she was supposed to do. ULP-F redirected R1 and then a few minutes later R1 would repeat the questions she had just asked. ULP-F left R1's apartment and documented the administration of all medications including Benefiber. The surveyor inquired if ULP-F returned to R1's room to ensure R1 drank all of the water with Benefiber and ULP-F stated she did not. On July 7, 2026, at 9:30 a.m., the surveyor returned to R1's apartment and noted the water glass sitting on R1's side table. The surveyor inquired if R1 usually drank all of the water with her Benefiber in it. R1 stated she wasn't aware she was supposed to drink all of it and stated it	01760		

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01760	Continued From page 25 was old water and didn't think she'd drink the rest of it. On July 8, 2026, at 11:29 a.m., clinical nurse supervisor (CNS)-C stated the ULP should stay with R1 until she finished drinking the water with Benefiber mixed in with it. CNS-C stated the ULP should not have documented the Benefiber was administered if they did not witness R1 drink the entire glass of water with Benefiber in it. The licensee's Administration of Medications, Treatment and Therapy by Unlicensed Personnel policy dated February 15, 2022, indicated the ULP would document, after assistance with self-administration of medications or medication, treatment and therapy administration, consistent with our facility's procedures for documenting in the MAR. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01790 SS=D	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a	01790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30490	A. BUILDING: _____ B. WING _____	07/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLSTREAM COMMONS	210 WEST 8TH STREET NORTHFIELD, MN 55057

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01790	Continued From page 26 medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was	01790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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MILLSTREAM COMMONS	210 WEST 8TH STREET NORTHFIELD, MN 55057

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01790	Continued From page 27 completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) trained and competency tested one of two unlicensed personnel (ULP-E) providing medications to residents for unplanned time away from home when the licensed nurse was not available. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-E was hired on August 22, 2024, to provide direct care and services to the facility's residents. On July 7, 2026, at 12:17 p.m., the surveyor observed ULP-E administer medications to R3. ULP-E's employee record lacked evidence of training and competency for providing medications for unplanned time away when the RN was not available.	01790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01790	Continued From page 28 On July 8, 2026, at 11:41 a.m., quality consultant (QC)-G stated training and competency for providing medications to residents for unplanned time away when the RN was not available was part of the new hire orientation for all ULP. However, after review of ULP-E's employee record QC-G stated it did not include this training or competency. The licensee's Medications to be Given When Away From Home policy dated August 1, 2021, indicated for situations when there will be a short-term absence (not to exceed seven calendar days) that is not known in advance and a licensed nurse is not available to put the medications into a container for the resident or the resident's responsible person to take out of the building, the RN will train unlicensed staff to follow the policy when giving mediations to the resident or resident's responsible person to take out of the building. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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MILLSTREAM COMMONS	210 WEST 8TH STREET NORTHFIELD, MN 55057

(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
01940	Continued From page 29 management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of three residents (R1). 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).	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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MILLSTREAM COMMONS	210 WEST 8TH STREET NORTHFIELD, MN 55057

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01940	Continued From page 30 The findings include: R1 was admitted on July 1, 2024, with diagnoses that included high blood pressure. On July 7, 2026, at 8:49 a.m., the surveyor observed unlicensed personnel (ULP)-F attempt to put R1's compression stockings and ace wraps on; however, R1 refused to wear either of them. R1's service plan dated February 23, 2026, indicated R1 received services to include dressing, mobility/ambulation, thrombo-embolic deterrent (TED) stockings (stockings designed to prevent blood clots and swelling in legs) and medication administration. R1's service plan did not include weekly weights and ACE wraps. R1's medication administration record (MAR) dated July 2026, included the following: -Weekly weight: check one time per day on Mondays R1's monthly task log dated July 2026, included the following: -Ace wraps: needs assistance with ace wraps, apply in the morning and take off in the evenings R1's record contained an after visit summary (AVS) dated April 7, 2026, that included the following note: -check weight once per week. Please follow up if you have increase in your weight or increased swelling. R1's record contained an AVS dated July 1, 2026, that included the following note: -Wrap legs with compression wrap/ACE wraps snuggly but not tight in the a.m., and off at night.	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01940	Continued From page 31 Elevate feet when sitting. Sleep in bed when able. Staff to remind her nightly to sleep in bed. Neither AVS dated April 7, 2026, and July 1, 2026, were signed by R1's provider. R1's record lacked signed prescriber orders for weekly weights and ACE wraps. R1's Individualized Treatment/Therapy Management Plan (found within the service plan) dated February 23, 2026, failed to include the following; -statement of the type of services that will be provided (weekly weights, ACE wraps) On July 8, 2026, at 11:35 a.m., clinical nurse supervisor (CNS)-C reviewed R1's treatment plan and stated it did not include weekly weights and ACE wraps. CNS-C stated the ACE wraps were a new treatment and should have been added to the service plan and treatment plan. CNS-C stated she was unsure why the weekly weights were not included in the treatment plan and stated it must have been an oversight. The licensee's Individualized Medication, Treatment and Therapy Management policy dated May 17, 2022, indicated the licensee would develop and maintain a current individualized treatment management record for each resident based on the resident's assessment that must contain the following: g. A statement describing the medication, treatment and therapy management services that will be provided; h. A description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions;	01940		

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01940	Continued From page 32 i. Documentation of specific resident instructions relating to the administration of medications, treatment and therapy services; j. Identification of persons responsible for monitoring medication, treatment and therapy supplies and ensuring that refills are ordered on a timely basis; k. Identification of medication, treatment and therapy management tasks that may be delegated to unlicensed personnel; l. Procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication, treatment and therapy management services; and Any resident-specific requirements relating to documenting medication, treatment and therapy administration, verifications that all medications, treatments and therapy services are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered	01960		

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01960	Continued From page 33 and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure treatment or therapies were administered as prescribed, or to document the reason they were not provided, for one of three 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 was admitted on September 30, 2025, with diagnoses that included diabetes. R2's service plan dated March 3, 2026, indicated R2 received services to include medication administration and blood glucose monitoring. R2's MAR dated July 2026, included the following: -Blood Sugar: Check twice a day at 11:15 a.m., and 4:15 p.m. -Insulin Aspart FlexPen 100 units/milliliter (ml); Inject 4 units subcutaneously two times a day at 11:15 a.m., and 4:15 p.m., if blood sugar is lower than 200, HOLD insulin. On July 7, 2026, at 7:27 a.m., the surveyor	01960		

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01960	Continued From page 34 observed unlicensed personnel (ULP)-E log into R2's electronic health record (EHR), remove two medication cards from the medication cart, verify the orders and punched the medications out of the card into a medication cup. ULP-E then removed R2's glucometer and brought the medication and glucometer to R2's room. ULP-E administered R2's medications and then checked R2's blood sugar which was 209. ULP-E stated R2 had an order to administer insulin if R2's blood sugar was 200 or greater. ULP-E returned to the medication cart, logged into R2's EHR to verify the insulin order. At this time, ULP-E noticed that R2 did not have an order to check her sugar in the morning or an order to administer insulin in the morning. ULP-E stated that according to the medication administration record (MAR), R2's blood sugar checks and insulin administration were scheduled before the lunch and dinner meal and not in the morning before breakfast. ULP-E stated R2 used to have morning blood sugar checks; however, it must have changed. ULP-E stated she should have checked R2's MAR before checking her blood sugar instead of going by her memory. On July 8, 2026, at 11:37 a.m., clinical nurse supervisor (CNS)-C stated ULP-E had reported to her that she checked R2's blood sugar when it was not ordered the morning of July 7, 2026. CNS-C stated she expected the ULP to verify all medication and treatment orders via the resident MAR prior to administering any medications or treatments. The licensee's Administration of Medications, Treatment and Therapy by Unlicensed Personnel policy dated February 15, 2022, indicated medications, treatment and therapy always need to be administered according to the "6 Rights"	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01960	Continued From page 35 a. Right person b. Right medication, treatment or therapy c. Right time d. Right route (by mouth, eye drops, to the skin, etc.) e. Right dose (how many milligrams, drops, etc.) f. Right chart/record to document that the medication, treatment and therapy was taken No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for one of three residents (R1) receiving treatments. 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	01970		

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01970	Continued From page 36 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: R1 was admitted on July 1, 2024, with diagnoses that included high blood pressure. On July 7, 2026, at 8:49 a.m., the surveyor observed unlicensed personnel (ULP)-F attempt to put R1's compression stockings and ace wraps on; however, R1 refused to wear either of them. R1's service plan dated February 23, 2026, indicated R1 received services to include dressing, mobility/ambulation, thrombo-embolic deterrent (TED) stockings (stockings designed to prevent blood clots and swelling in legs) and medication administration. R1's service plan did not include weekly weights and ACE wraps. R1's medication administration record (MAR) dated July 2026, included the following: -Weekly weight: check one time per day on Mondays R1's monthly task log dated July 2026, included the following: -Ace wraps: needs assistance with ace wraps, apply in the morning and take off in the evenings R1's record contained an after visit summary (AVS) dated April 7, 2026, that included the following note: -check weight once per week. Please follow up if you have increase in your weight or increased swelling.	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01970	Continued From page 37 R1's record contained an AVS dated July 1, 2026, that included the following note: -Wrap legs with compression wrap/ACE wraps snuggly but not tight in the a.m., and off at night. Elevate feet when sitting. Sleep in bed when able. Staff to remind her nightly to sleep in bed. Neither AVS dated April 7, 2026, and July 1, 2026, were signed by R1's provider. R1's record lacked signed prescriber orders for weekly weights and ACE wraps. On July 8, 2026, at 11:38 a.m., clinical nurse supervisor (CNS)-C stated R1's record lacked signed prescriber orders for weekly weights and ACE wraps. CNS-C stated she would request signed orders for both treatments. The licensee's Requesting and Receiving Prescriptions policy dated April 8, 2022, indicated the following: -the registered nurse (RN) or licensed practical nurse (LPN) will take necessary steps to obtain the prescriber's signature on any verbal orders or prescriptions as soon as possible and will document efforts to obtain the necessary signature -the RN will evaluate the effectiveness of the medication, treatment or therapy that has been prescribed or ordered and will report any concerns to the prescriber. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		

Mankato District Office
Minnesota Department of Health
12 Civic Center Plaza, Suite 2105
Mankato, MN 56001
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

MILLSTREAM COMMONS
210 West 8th Street
Northfield, MN 55057
Rice County
Parcel:

Phone:

License Info

License: HFID 30490

Risk:
License:
Expires on:
CFPM: Richard Graske
CFPM #: 67901; Exp: 4/2/2029

Inspection Info

Report Number: F7990261012
Inspection Type: Full - Single
Date: 7/6/2026 Time: 10:22:48 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery:

No orders were issued for this inspection report.

Food & Beverage General Comment

WE DISCUSSED EMPLOYEE ILLNESS, COOLING, HANDWASHING, BAREHAND CONTACT AND NOROVIRUS PREVENTION. AN EMPLOYEE ILLNESS LOG WAS ONSITE.

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 Mankato District Office inspection report number F7990261012 from 7/6/2026

Benjamin D. Ische

Richard Graske

Ben Ische,
Public Health Sanitarian Supervisor
507-344-2710
ben.ische@state.mn.us

Mankato District Office
Minnesota Department of Health
12 Civic Center Plaza, Suite 2105
Mankato, MN 56001

Temperature Observations/Recordings

Establishment Info

MILLSTREAM COMMONS
Northfield
County/Group: Rice County

Inspection Info

Report Number: F7990261012
Inspection Type: Full
Date: 7/6/2026
Time: 10:22:48 AM

Food Temperature: Product/Item/Unit: CHEESE**; Temperature Process:** Cold-Holding
Location: Walk-in Cooler at 40 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: HAMBURGER PATTY**; Temperature Process:** Cooking
Location: Flat Top at 156 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: WHITE SINGLE DOOR BEVERAGE COOLER**; Temperature Process:** Ambient Air
Location: Reach-in Cooler at 40 Degrees F.
Comment:
Violation Issued?: No

Mankato District Office
Minnesota Department of Health
12 Civic Center Plaza, Suite 2105
Mankato, MN 56001

Sanitizer Observations/Recordings

Establishment Info

MILLSTREAM COMMONS
Northfield
County/Group: Rice County

Inspection Info

Report Number: F7990261012
Inspection Type: Full
Date: 7/6/2026
Time: 10:22:48 AM

Sanitizing Chemical: **Product:** Chlorine**; Sanitizing Process:** Dish Machine
Location: Dishwashing Area **Equal To** 100 PPM
Comment:
Violation Issued?: No

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** Wiping Cloth Bucket
Location: Cook Line **Equal To** 200 PPM
Comment:
Violation Issued?: No

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** 3-Compartment Sink
Location: Dishwashing Area **Equal To** 200 PPM
Comment:
Violation Issued?: No

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL30490017-0	**Date:** July 15, 2026
Facility Name: MILLSTREAM COMMONS	
Facility Address: 210 WEST 8TH ST, NORTHFIELD, MN 55057	

☒ **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. In buildings that contain a fuel-burning appliance or fireplace, or attached private garage, carbon monoxide detection shall be installed in dwelling units within ten feet of bedrooms. Where a fuel burning appliance is located in a bedroom or its attached bathroom, carbon monoxide detection shall be installed within the bedroom. Carbon monoxide detection can be provided by carbon monoxide alarms installed in dwelling or sleeping units or a carbon monoxide detection system installed in the room or space that contains the fuel-burning appliance. [Minn. Stat. 144G.45 subd. 2; MSFC 915]

   Comments: The facility didn't have carbon monoxide alarms in the resident rooms or alarms connected to the fire alarm panel at the source of fuel fire appliances.

3. Single- and multiple-station smoke alarms shall be replaced when they fail to respond to operability tests or exceed ten years from the date of manufacture. Smoke alarms shall be replaced with smoke alarms having the same type of power supply. [Minn. Stat. 144G.45 subd. 2; MSFC 1103.8.1]

   Comments: During testing of resident room smoke alarms throughout the facility it was observed that the alarms were over 10 years old from the manufacture date.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Twenty One (21) days

1. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include employee actions to be taken in the event of a fire or similar emergency. [Minn. Stat. 144G.45 subd.2]

   Comments: The FSEP failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate).

2. Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. [Minn. Stat. 144G.45 subd.2]

   Comments: Environmental services director (ESD)-I lacked documentation showing any staff training was offered in 2025 or 2026 on the fire safety and evacuation plan.

3. Evacuation drills are required for employees 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. [Minn. Stat. 144G.45 subd.2]

   Comments: Licensee provided documents showing four total evacuation drills in 2025 and three in 2026. Documents provided show drills didn't occur twice per year, per shift, or every other month. No other information or documentation was provided.