Electronically Delivered

June 9, 2026

Licensee
Ridgeview Assisted Living LLC
2020 Ridgeview Drive
International Falls, MN 56649

RE: Project Number(s) SL30482016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 7, 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:

1290 - 144g.60 Subdivision 1 - Background Studies Required - $1,000.00

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

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

The correction order documentation should include the following:

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

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

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

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

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you

may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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

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

If you have any questions, please contact me.

Sincerely,

Jessie Chenze

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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30482	A. BUILDING: _____ B. WING _____	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEVIEW ASSISTED LIVING LLC	2020 RIDGEVIEW DRIVE INTERNATIONAL FALLS, MN 56649

(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: SL30482016-0 On May 5, 2026, through May 7, 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 12 residents; 12 receiving services under the Assisted Living Facility license. An immediate correction order was identified on May 6, 2026, issued for SL30482016-0, tag identification 1290. The licensee took action on May 6, 2026, to mitigate the risk; however, the scope and level remains at level 3/Widespread (I).	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 430 SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services	0 430		

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0 430	Continued From page 1 (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to revise and provide an up-to-date Uniform Disclosure of Assisted Living Services & Amenities (UDALSA) to all residents. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living facility license effective July 1, 2025, with an expiration	0 430		

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0 430	Continued From page 2 date of June 30, 2026. During the entrance conference on May 5, 2026, at 11:01 a.m., clinical nurse supervisor (CNS)-B stated the licensee was familiar with current minimum assisted living requirements. On May 5, 2026, from 1:22 p.m., through 1:49 p.m., the surveyor toured the facility with CNS-B and registered nurse (RN)-C. The surveyor did not observe a secured (requires a code entered on a keypad to exit the facility) building and all doors were able to be opened by residents, staff, and visitors. The licensee's UDALSA dated October 1, 2025, indicated the licensee has an assisted living facility license. In addition, Section 1: Dementia Care (pertains only to an Assisted Living with Dementia Care license) indicated the following: -secured unit or building for wandering or exit-seeking behavior; and -individualized digital/alarm monitoring for wandering or exit-seeking behavior. The licensee's UDALSA lacked current documentation of services provided by the licensee, as the licensee was not licensed as an assisted living facility with dementia care. On May 7, 2026, at 11:40 a.m., licensed assisted living director (LALD)-A stated the licensee does not have a secured building, however, the licensee did install alarms on all exit doors to notify staff of any residents or visitors entering or exiting the building. LALD-A further stated the licensee's UDALSA should not have included information listed under the dementia care section as the licensee was not licensed as an assisted living with dementia care facility.	0 430		

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0 430	Continued From page 3 The licensee's 1.04 UDALSA policy dated May 23, 2023, indicated (licensee name) will complete the provided form (UDALSA) and keep current at all times. In addition, the facility UDALSA will disclose the category of license held and will list all services and amenities permitted under the facility's license, identifying all services and amenities the facility offers to provide and does not provide. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0090, Subp. 4, effective October 2022, a facility shall provide an up-to-date checklist to each prospective resident and each prospective resident's representatives who request information about the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 430		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and	0 680		

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0 680	Continued From page 4 (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 develop a written emergency preparedness plan (EPP) with all the required content defined in Appendix Z. This had the potential to affect 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 has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on May 5, 2026, at 11:01 a.m., clinical nurse supervisor (CNS)-B stated the licensee was familiar with current minimum assisted living requirements. The licensee's EPP lacked the following required content:	0 680		

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0 680	Continued From page 5 - exercises to test the EPP at least twice per year, including unannounced staff drills using the EPP to include: - participate in an annual full-scale exercise that is community based or conduct an annual, individual, facility-based functional exercise or if the facility experiences an actual emergency requiring activation of the plan, the facility is exempt from engaging in its next required full-scale exercise. - conduct an additional annual exercise that may include a second full-scale exercise that is community based or an individual, facility based functional exercise or mock disaster drill or table-top exercise; and - analyze the facility's response to and maintain documentation of all drills, tabletop exercises and emergency events and revise the plan as needed. On May 7, 2026, at 11:16 a.m., licensed assisted living director (LALD)-A stated LALD-A and unlicensed personnel (ULP)-E had updated the licensee's EPP together and LALD-A needed to locate the documentation of the licensee's EPP exercises completed for 2024 and 2025, however, no additional documentation was provided. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0100, sections A and B, effective October 2022, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types:	0 680		

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0 680	Continued From page 6 Interpretive Guidance," which is incorporated by reference. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is	0 810		

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0 810	Continued From page 7 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 Environment Inspection Report (PEIR) dated May 6,2026, 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	01290		

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01290	Continued From page 8 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 current employee records contained all the required content to include a current background study clearance letter for one of five employees (unlicensed personnel (ULP)-E). This had the potential to affect all residents living within the facility. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: This resulted in an immediate correction order on May 6, 2026.	01290		

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01290	Continued From page 9 **REVISED on May 27, 2026, to correct identifier from LALD-D to LALD-A** During the entrance conference on May 5, 2026, at 11:20 a.m., licensed assisted living director (LALD)-A stated the licensee was aware of required contents in an employee record. ULP-E was hired on May 12, 2021, and effective August 1, 2021, began to provide direct assisted living services to residents. The licensee's May 4, 2026 - May 10, 2026, schedule indicated ULP-E was scheduled to work May 5, 2026, May 6, 2026, May 7, 2026, and May 8, 2026, respectively, from 2:00 p.m. until 10:00 p.m. shift. On May 5, 2026, at 2:15 p.m., the surveyor observed ULP-E provide snacks to six residents at the dining room table. ULP-E was unsupervised. The licensee's undated NETStudy 2.0 Roster indicated ULP-E's employee background study was Eligible- COVID-19- Study- Expired on December 31, 2022. On May 5, 2026, at 2:50 p.m., LALD-A stated LALD-A was responsible for completing employee background checks on the Minnesota Department of Human Services (MN DHS) NETStudy 2.0 website. LALD-A stated LALD-A was responsible for completing background checks for the facility. LALD-A confirmed ULP-E was not supervised. Additionally, LALD-A stated because ULP-E's expired COVID-19 study appeared green on the roster, he was not aware the study expired.	01290		

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01290	Continued From page 10 The licensee's 4.02 Background Studies policy dated May 23, 2023, indicated (licensee name) will initiate a background study on all employees using the MN DHS NetStudy online program [sic]. The MN DHS Background Studies website last updated March 30, 2026, indicated "DHS temporarily modified background studies during COVID-19, but modifications ended January 1, 2023, and emergency studies are no longer valid." Continuous Direct Supervision defined in NETStudy 2.0 System User Manual Updated July 7, 2023, page 7: Continuous, Direct Supervision - An individual is within sight or hearing of the program's supervising individual to the extent that the program's supervising individual is capable at all times of intervening to protect the health and safety of the people served by the program. Direct Contact Services - Providing face-to-face care, training, supervision, counseling, consultation, or medication assistance to people served by the entity. Supervision defined in, NETStudy 2.0 System User Manual Updated July 7, 2023, page 53: Supervision Status Study subjects must be under continuous, direct supervision until the study subject is determined eligible until the entity is notified by DHS that the study subject may provide unsupervised services while the background study is being completed. The supervision status is shown in the "Supervision Required" column for convenience. However, programs are instructed to rely on background study notices for supervision status and other background study determination information.	01290		

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01290	Continued From page 11 No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living	01620		

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01620	Continued From page 12 services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted assessments with the uniform assessment tool that included all required content for one of three residents (R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on May 5, 2026, at 11:11 a.m., clinical nurse supervisor (CNS)-B stated an RN completed a preadmission resident	01620		

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01620	Continued From page 13 assessment, a comprehensive assessment on admission, 14 days after admission, and then at least every 90 days unless the resident had a change of condition. R6's diagnoses included Alzheimer's and hypertension (HTN-high blood pressure). R6's Service Plan Agreement dated April 25, 2026, indicated R6's services included safety checks for wandering (including a resident wristband transmitter) five times per day, and checking the resident wristband transmitter each shift. On May 7, 2026, at 9:58 a.m., unlicensed personnel (ULP)-D stated R6 wore a wristband, which notified staff if R6 was near a facility exit and R6 needed supervision if R6 went outside of the facility for safety. The surveyor observed R6 asleep in R6's bed. R6's Progress Notes for [resident name] dated April 24, 2025, written by RN-F indicated licensed assisted living director (LALD) discussed resident's risk for elopement with [resident's representative name], RR (resident representative). LALD explained to RR that because she (R6) is confused and ambulatory with delusional ideations, when he leaves she (R6) may attempt to follow him out. RR agreed to make staff aware of when he leaves so that staff can monitor her (R6) whereabouts more closely. LALD explained the use of the smart watch. RR in agreement with using the resident wristband transmitter. The resident wristband transmitter has been applied to resident's left wrist without difficulty. Resident was informed of the purpose of the resident wristband transmitter. Resident verbalized understanding.	01620		

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01620	Continued From page 14 R6's Master Assessment- Testing dated May 26, 2025, was completed by RN-F. The assessment indicated R6 was assessed including the use for a resident wristband transmitter on R6's left wrist. R6's Master Assessment- Testing dated April 25, 2026, lacked evidence R6 was assessed by the RN for the use of the resident wristband transmitter. On May 7, 2026, at 11:40 a.m., LALD-A and RN-C stated R6 still wore the resident wristband transmitter to notify staff if R6 was leaving the facility and to provide supervision of R6. RN-F further stated R6's assessments should have included the use of the resident wristband transmitter, and RN-F would look for additional documentation. On May 7, 2026, at 12:06 p.m., RN-F stated RN-F was unable to locate any of R6's comprehensive assessments, which included the assessment of the resident wristband transmitter. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0140, Subp. 2, effective October 2022, a nursing assessment or reassessment under Minnesota Statutes, section 144G.70, subdivision 2, paragraphs (b) and (c), must be conducted on a prospective resident or resident receiving any of the assisted living services identified in Minnesota Statutes, section 144G.08, subdivision 9, clauses (6) to (12). B. The nursing assessment or reassessment under item A must: (1) address part 4659.0150, subpart 2, items A to N; (2) be conducted in person unless an exception under Minnesota Statues, section 144G.70,	01620		

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01620	Continued From page 15 subdivision 2, paragraph (b), applies; (3) be conducted using a uniform assessment tool that complies with part 4659.0150; and (4) be in writing, dated, and signed by the registered nurse who conducted the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and	01650		

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01650	Continued From page 16 declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure service plans included the required content for two of two residents (R2, 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on May 5, 2026, at 11:01 a.m., clinical nurse supervisor (CNS)-B stated the licensee was familiar with current minimum assisted living requirements. R2 R2's diagnoses included diabetes, hypertension (HTN-high blood pressure), and mild confusion. R2's Service Plan Agreement dated April 18, 2026, indicated R2's services included medication administration, blood glucose checks, safety checks, housekeeping, and laundry. On May 6, 2026, at 7:21 a.m., the surveyor observed unlicensed personnel (ULP)-D administer R2's scheduled morning medication.	01650		

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01650	Continued From page 17 R3 R3's diagnoses included type 2 diabetes mellitus with chronic kidney disease, essential hypertension, and unspecified atrial flutter. R3's Service Plan Agreement dated March 2,2026 indicated R3's services include services included medication administration, blood glucose checks, safety checks, housekeeping, and laundry. On May 6, 2026, at 8:08 a.m., the surveyor observed ULP-D administer R3's scheduled morning medications. R2 and R3's service plans indicated a registered nurse (RN) will review and monitor all health-related services provided to the Client (resident) within 5 (five) days of admission and at 14 days since admission and then at least every 90 days thereafter, or more frequently if indicated by a nursing assessment, done in person and or by record review [sic]. R2 and R3's service plans lacked the schedule and methods of monitoring assessments of residents per assisted living regulations. On May 7, 2026, at 11:18 a.m., RN-F stated RN-F was responsible for completing resident's service plans. RN-F further stated the licensee's electronic medical record system made a template of the service plans, however, the template referred to home care regulations. Licensed assisted living director (LALD)-A stated the same service plan template was used for all residents. The licensee's 6.08 Service Plan policy dated March 20, 2024, indicated the service plan will	01650		

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01650	Continued From page 18 include a schedule and method for the next planned assessment or monitoring. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01760 SS=F	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 the steps of the medication administration process was followed for one of one employee (unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	01760		

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01760	Continued From page 19 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on May 5, 2026, at 11:06 a.m., clinical nurse supervisor (CNS)-B and registered nurse (RN)-C stated the licensee provided medication management services to residents at the facility. ULP-D's employee record included a passed 2.24 Medication Administration- Injections-Subcutaneous (SQ-fatty layer between skin and muscle) Competency dated August 4, 2025. R2 R2's diagnoses included diabetes, hypertension (HTN-high blood pressure), and mild confusion. R2's Service Plan Agreement dated April 18, 2026, indicated R2's services included medication administration. R2's prescriber orders dated April 16, 2026, included an order for Lantus 100 units/milliliter (mL) inject 18 units SQ every 12 hours. R2's Medication Administration Record (MAR) dated April 2026, and May 2026, respectively, indicated effective April 8, 2026, R2 was administered Lantus 18 units SQ every 12 hours. On May 6, 2026, at 7:35 a.m., the surveyor observed ULP-D compare R2's Lantus insulin pen to R2's electronic medication administration record (EMAR). ULP-D dialed R2's Lantus insulin to 18 units, ULP-D had R2 verify the Lantus	01760		

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01760	Continued From page 20 insulin pen was dialed to 18 units, and ULP-D administered R2's insulin. The surveyor did not observe ULP-D prime the Lantus insulin pen with two (2) units of insulin and discard prior to dialing up the dosage of the Lantus insulin pen to ensure the needle contained insulin and allowed R2 to get the full dosage of insulin as prescribed. On May 7, 2026, at 8:40 a.m., ULP-D stated ULP-D had primed new insulin pens upon opening, however, ULP-D did not prime insulin pens before administration after the first use. On May 7, 2026, at 11:22 a.m., RN-C stated RN-C had just completed a staff training on the insulin pen administration process. RN-C further stated ULPs were trained to prime insulin pens by attaching the needle, dialing the insulin pen to two units, and discarding the two units before dialing the insulin pen to the prescribed dosage. The manufacturer's instructions for Lantus dated May 2016, indicated to always perform a safety test prior to each injection by selecting a dose of two (2) units, press the injection button to ensure insulin comes out of the needle tip, and then proceed to dial the insulin pen to the prescribed dosage for administration. The licensee's 7.36 Insulin policy dated May 23, 2023, did not address priming the insulin pen prior to administration. R4 R4's diagnoses included diabetes, HTN, and gastro-esophageal reflux disease (GERD- acid reflux). R4's Service Plan Agreement dated August 17, 2025, indicated R4's services included	01760		

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01760	Continued From page 21 medication administration. R4's prescriber orders dated February 10, 2026, included an order for Pantoprazole (for GERD) 40 milligrams (mg) by mouth daily at 7:00 a.m. Pantoprazole is best given before breakfast or 30 to 60 minutes before a meal. R4's Medication Administration Record (MAR) dated April 2026, and May 2026, respectively, indicated R4 received Pantoprazole 40 mg daily at 7:00 a.m. On May 6, 2026, at 8:27 a.m., the surveyor observed ULP-D assist R4 to the medication room after R4 had completed eating breakfast at the dining room table. ULP-D stated R4's Pantoprazole 40 mg was scheduled for 7:00 a.m., and ULPs had one hour before and one hour after the scheduled medication time to administer the medication. ULP-D administered R4's Pantoprazole 40 mg. The surveyor did not observe ULP-D contact the RN and inform the RN of R4's Pantoprazole 40 mg being administered over one hour after the scheduled administration time and after R4 had consumed breakfast. On May 7, 2026, at 11:25 a.m., RN-C stated R4's Pantoprazole was supposed to be administered prior to R4 being served breakfast. RN-C further stated ULPs were trained to follow the instructions written on R4's EMAR. The licensee's 7.24 Medication Error policy dated May 23, 2023, indicated whenever a medication error occurs, the person responsible for the error or the person who caught the medication error will contact a licenses nurse and explain the situation in detail with the medication name,	01760		

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01760	Continued From page 22 dosage and amount given as well as the resident involved. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record all required content for disposition of the medications for one of one resident (R1) upon discharge.	01910		

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01910	Continued From page 23 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 May 5, 2026, at 11:06 a.m., clinical nurse supervisor (CNS)-B, and registered nurse (RN)-B stated the licensee provided medication management to residents at the facility. The licensee's Discharged or Deceased Resident Roster: State Evaluations dated April 6, 2026, indicated R1 was admitted to the assisted living facility on December 18, 2025, and was discharged on January 22, 2026. R1's diagnoses included Alzheimer's, dementia, disorientation, dizziness and giddiness, and osteoarthritis. R1's Service Plan agreement dated December 31, 2025, indicated R1's services included mediation administration. R1's Medication Administration Record dated December 2025, and January 2026, respectively, indicated R1 received the following medications: -Amlodipine Besylate (antihypertensive) 10 milligrams (mg) daily -Aspirin (stroke prevention) 81 mg daily -Clonazepam (for dementia) 0.5 mg twice daily	01910		

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01910	Continued From page 24 -Donepezil HCL (for Alzheimer's) 5 mg daily at bedtime -Ensure Nutritional Shake Liquid (for extra protein and calories) twice daily -Escitalopram Oxalate (for dementia) 10 mg twice daily -Isosorbide Mononitrate ER (antihypertensive) 30 mg daily -Spironolactone (antihypertensive) 25 mg give half tab (12.5 mg) daily -Systane Pro (for dry eyes) 0.6% solution one drop into each eye twice daily -Zofran (antinausea) 4 mg every 8 hours as needed. R1's prescriber orders dated December 29, 2025, included the above noted medications. R1's Progress Notes for (resident name) dated January 22, 2026, indicated R1 was discharged to a skilled nursing facility, and all medications were sent with R1's granddaughter to give to the skilled nursing facility staff. R1's record lacked documentation for the disposition of the above noted medications to include the medication's name, strength, prescription number as applicable, quantity to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition . On May 7, 2026, at 11:01 a.m., RN-C stated the licensee used a form when destructing medications which included all required content for medication disposition, however, RN-C stated the licensee did not document the disposition of medications when R1's medications were given to R1's granddaughter. RN-C further stated RN-C had only documented in R1's progress note to	01910		

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	30482	A. BUILDING: _____ B. WING _____	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEVIEW ASSISTED LIVING LLC	2020 RIDGEVIEW DRIVE INTERNATIONAL FALLS, MN 56649

(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
01910	Continued From page 25 indicate R1's medications were given to R1's granddaughter. The licensee 7.23 Medication Disposal policy dated May 23, 2023, indicated current unused medications managed by (facility name) will be returned to the pharmacy for credit, or given to the resident or the resident's representative, when the resident's medications are no longer managed by the facility or the medication has been discontinued by the prescriber. Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		

Bemidji District Office
Minnesota Department of Health
709 5th St NW, Suite A
Bemidji, MN 56601
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Ridgeview Assisted Living LLC
2020 RIDGEVIEW DRIVE

International Falls, MN 56649
Koochiching County
Parcel:

Phone:

License Info

License: HFID 30482

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

Inspection Info

Report Number: F1019261043
Inspection Type: Full - Single
Date: 5/6/2026 Time: 2:12:12 PM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

DISCUSSION: OTHER DRY STORAGE AREAS, DISH MACHINE TESTING, CFPM LICENSING,

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

I acknowledge receipt of the Bemidji District Office inspection report number F1019261043 from 5/6/2026

JUSTIN J. TAYLOR
CFPM

Jared Morrill,
Public Health Sanitarian 3
218-308-2128
jared.morrill@state.mn.us

Bemidji District Office
Minnesota Department of Health
709 5th St NW, Suite A
Bemidji, MN 56601

Temperature Observations/Recordings

Establishment Info

Ridgeview Assisted Living LLC
International Falls
County/Group: Koochiching County

Inspection Info

Report Number: F1019261043
Inspection Type: Full
Date: 5/6/2026
Time: 2:12:12 PM

Equipment Temperature: Product/Item/Unit: KITCHEN FRIDGE**; Temperature Process:** Cold-Holding
Location: at 40 F Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: COOKED BROCOLLI**; Temperature Process:** Cooking
Location: at 163 F Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: BASEMENT FRIDGE**; Temperature Process:** Cold-Holding
Location: at 39 F Degrees F.
Comment:
Violation Issued?: No

Bemidji District Office
Minnesota Department of Health
709 5th St NW, Suite A
Bemidji, MN 56601

Sanitizer Observations/Recordings

Establishment Info

Ridgeview Assisted Living LLC
International Falls
County/Group: Koochiching County

Inspection Info

Report Number: F1019261043
Inspection Type: Full
Date: 5/6/2026
Time: 2:12:12 PM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Kitchen **Equal To** 162 Degrees F.
Comment:
Violation Issued?: No

Minnesota (MDH) Version
EH Manager; RPT: F1019261043

Food Establishment Inspection Report

Bemidji District Office
Minnesota Department of Health
709 5th St NW, Suite A
Bemidji, MN 56601

No. of Risk Factor/Intervention/Violations	0	Date: 5/6/2026
No. of Repeat Risk Factor/Intervention/Violations		Time: 2:12:12 PM
Score (optional)		Dur: min

Establishment:	Address:	City/State:	Zip:	Phone:
Ridgeview Assisted Living LLC	2020 RIDGEVIEW DRIVE	International Falls, MN	56649	
License/Permit #:	**Permit Holder:**	**Purpose of Inspection:**	**Est. Type:**	**Risk Category:**
HFID 30482		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

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

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

Person in Charge (signature)

Inspector (signature)

Follow-up: Follow-up Date:

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL30482016-0	**Date:** 5/6/2026
Facility Name: RIDGEVIEW ASSISTED LIVING LLC	
Facility Address: 2020 Ridgeview Dr, International Falls, Minnesota 56649	

☒ **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 provided FSEP was from a third-party provider and had not been updated to the specific facility.

2. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include fire protection procedures necessary for residents. [Minn. Stat. 144G.45 subd.2]

   Comments: The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency.

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: The licensee failed to conduct evacuation drills for employees twice per year per shift, as required, with at least one drill occurring every other month. Documentation provided during the survey showed that all evacuation drills were conducted during the months of August, October and December of 2026. Drills were also conducted with multiple shifts participating in one drill.