Electronically Delivered

August 7, 2025

Licensee
The Pillars of Grand Rapids
2060 Southwest 8th Street
Grand Rapids, MN 55744

RE: Project Number(s) SL38392016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 11, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;

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

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00

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

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

The correction order documentation should include the following:

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

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

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

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

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

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

the website listed above.

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

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

If you have any questions, please contact me.

Sincerely,

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38392	A. BUILDING: _____ B. WING _____	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PILLARS OF GRAND RAPIDS	2060 SW 8TH STREET GRAND RAPIDS, MN 55744

(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: SL38392016-0 On June 9, 2025, through June 11, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 113 residents; 59 receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and	0 510		

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0 510	Continued From page 1 maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program to comply with accepted health care, medical, and nursing standards for infection control for one of six employees (unlicensed personnel/ULP-H). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On June 11, 2025, at 7:05 a.m., the surveyor observed ULP-H and ULP-I assist R2 with morning cares. With gloved hands, ULP-H and ULP-I assisted R2 to stand. ULP-H removed R2's incontinent brief, provided perineal cares to the front and then the back, placed a new brief, and	0 510		

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0 510	Continued From page 2 applied Calmoseptine ointment to R2's groin. ULP-H then removed the glove from her left hand and placed it in her gloved right hand. At this time, both ULP-H and ULP-I assisted R2 to get into the wheelchair, ULP-H touched the handle of the wheelchair, removed R2's shirt, moved R2's walker, retrieved a new towel from the bathroom, washed and dried R2's underarms, removed the dirty laundry from the bed, retrieved an electric shaver from the bathroom and shaved R2's face, assisted to put a clean shirt on R2, touched the nebulizer equipment on the table, and went to the sink to wash her hands. On June 11, 2025, at 7:30 a.m., ULP-H stated she did not perform any hand hygiene after performing perineal cares or removing gloves, but should have. On June 11, 2025, at 9:10 a.m., clinical nurse supervisor (CNS)-A stated staff are expected to wash hand after removing gloves and after performing perineal cares. The licensee's Standard Infection Control Precautions policy dated August 1, 2022, noted staff were to wash hands after touching contaminated items, immediately after removing gloves, and "between tasks and procedures on the same client [resident] to prevent cross-contamination of different body sites, and between all client contacts." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		

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0 775	Continued From page 3	0 775		
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 and interview, the licensee failed to comply with the requirements of the Minnesota State Fire Code. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On a facility tour on June 10, 2025, from 10:15 a.m. to 12:00 p.m., with environmental services director (ESD)-D, the following observations were made of non-compliance with the requirements of the Minnesota State Fire Code (MSFC) in Minnesota Rules Chapter 7511: CONTROLLED EGRESS DOOR LOCKING SYSTEM During document review and interview on June 10, 2025, at 10:00 a.m. with ESD-D, it was observed the procedures of operation for the controlled egress door locking system in the	0 775		

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0 775	Continued From page 4 secured dementia care unit were not provided in the employee procedures of the fire safety and evacuation plan (FSEP). It was explained to ESD-D, the procedures for operation of the controlled egress door locking system are required to be included in the FSEP employee procedures. FIRE RESISTANT RATED TRASH CHUTE DOOR MAINTENANCE The fire-resistant rated trash chute doors on the first floor did not automatically close and positively latch. It was explained to ESD-D, the fire-resistant rated trash chute doors are required to automatically close and latch to prevent the spread of smoke and fire from inside the trash chute in the event of a fire in the trash chute. EQUIPMENT STORAGE IN EGRESS PATH The was two battery powered floor cleaning machines stored in the egress corridor near resident room 220 and resident room 420. It was explained to ESD-D, that the egress paths shall be kept free of storage and combustible equipment and maintained for full and immediate use in the event of a fire or similar emergency. FIRE-RESISTANT RATED DOOR MAINTENANCE The fire-resistant rated door leading into the office does not automatically close and positively latch in the office across from resident room 322.	0 775		

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0 775	Continued From page 5 It was explained to ESD-D, the fire-resistant rated doors are required to automatically close and latch to prevent the spread of smoke and fire from inside the office to the exit corridor. During the facility tour ESD-D, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		
0 780 SS=D	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;	0 780		

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0 780	Continued From page 6 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide interconnected smoke alarms with resident dwelling units. This had the potential to affect a limited number of 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 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: INTERCONNECTION On a facility tour on June 10, 2025, from 10:15 a.m. to 12:00 p.m., with environmental services director (ESD)-D, it was observed that smoke alarms were not interconnected so activation of one alarm activates all alarms in resident dwelling unit 300. It was explained to ESD-D, that all dwelling units required to have multiple smoke alarms are required to have interconnected alarms so activation of one alarm activates all alarms within the dwelling unit.	0 780		

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0 780	Continued From page 7 During the tour the smoke alarms were tested and ESD-D, verified the smoke alarms were not interconnected so activation of one alarm activates all alarms throughout the facility. TIME PERIOD FOR CORRECTION: Two (2) days.	0 780		
0 810 SS=E	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 8 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 provide required training to employees. This had the potential to affect more than a limited number of 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 was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On June 10, 2025, at 9:15 a.m., environmental services director (ESD)-D, and executive director (ED)-C, provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. TRAINING Record review of the available documentation indicated the licensee failed to provide training to employees on the FSEP at least twice per year as evident by providing documentation the	0 810		

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0 810	Continued From page 9 employees completed training at hire and one time per year thereafter. On June 10, 2025, at 1:31 p.m., ED-C, provided documentation of FSEP training completed by employees at hire and January 2024 only. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
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	01500		

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01500	Continued From page 10 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 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 interview and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of three employees (unlicensed personnel/ULP-E). This practice resulted in a level two violation (a	01500		

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01500	Continued From page 11 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 May 23, 2022, to provide direct care services to residents of the facility. ULP-E's employee record lacked documented evidence of the following required annual training: - principles of person-centered planning and service delivery. On June 11, 2025, at 10:55 a.m., executive director (ED)-C and clinical nurse supervisor (CNS)-A stated the training had been assigned, but ULP-E had not completed it. The licensee's Required Training - Annual/Bi-Annual policy dated January 2025, noted all direct-care employees would complete annual training including principles of person-centered planning and service delivery. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38392	A. BUILDING: _____ B. WING _____	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PILLARS OF GRAND RAPIDS	2060 SW 8TH STREET GRAND RAPIDS, MN 55744

(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
01760	Continued From page 12 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 an inhaler was administered per manufacturer instructions for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's diagnoses included Parkinson's disease, hypertension, and mild intermittent asthma with acute exacerbation. On June 11, 2025, at 7:30 a.m., the surveyor observed unlicensed personnel (ULP)-H administer medications to R2. ULP-H brought an	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38392	A. BUILDING: _____ B. WING _____	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PILLARS OF GRAND RAPIDS	2060 SW 8TH STREET GRAND RAPIDS, MN 55744

(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
01760	Continued From page 13 Advair Diskus 250 microgram (mcg)-50 mcg inhaler to R2 and administered one puff. ULP-H then administered oral medications that had been crushed in applesauce to R2. ULP-H then returned to the medication cart to document the administration. R2's Service Plan Agreement dated May 15, 2025, indicated R2 received services including assistance with medication administration and dressing. R2's June 2025, Medication Sheet included the following: - fluticas/salmeterol 250-20 inh (inhaler) (Advair Diskus 250 mcg-50 mcg) "Inhale 1 puff into the lungs two times a day. Rinse mouth after each use." On June 11, 2025, at 9:10 a.m., clinical nurse supervisor (CNS)-A stated if the instructions said to rinse the mouth after use, staff should rinse the mouth after use. The manufacturer's instructions for use dated 2008, noted "After each dose, rinse your mouth with water and spit the water out. Do not swallow." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		

Bemidji District Office
Minnesota Department of Health
710 5th St NW, Suite A
Bemidji, MN 56601
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

The Pillars of Grand Rapids
2060 SW 8th Street
GRAND RAPIDS, MN 55744
Itasca County
Parcel:

Phone:

License Info

License: HFID 38392

Risk:
License:
Expires on:
CFPM:
CFPM #: FM31981; Exp: 11-29-2026

Inspection Info

Report Number: F7939251049
Inspection Type: Full - Single
Date: 6/10/2025 Time: 12:06:21 PM
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

DISCUSSION
NOT OVER PACKING THE PREP TOP COOLER
BARE HAND CONTACT AND GLOVE USE
NEW DISH MACHINE TESTING

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 F7939251049 from 6/10/2025

CHRISTINE GIERSDORF
COOK/CFPM

Ryan Trenberth,
Public Health Sanitarian 3
218-308-2133
ryan.trenberth@state.mn.us

Bemidji District Office
Minnesota Department of Health
710 5th St NW, Suite A
Bemidji, MN 56601

Temperature Observations/Recordings

Establishment Info

The Pillars of Grand Rapids
GRAND RAPIDS
County/Group: Itasca County

Inspection Info

Report Number: F7939251049
Inspection Type: Full
Date: 6/10/2025
Time: 12:06:21 PM

Food Temperature: Product/Item/Unit: Chicken**; Temperature Process:** Cooking
Location: Fryer at 178 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Hard Boiled Eggs**; Temperature Process:** Cold-Holding
Location: Prep Cooler - top at 38 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Chicken**; Temperature Process:** Cold-Holding
Location: Prep Cooler - bottom at 37 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Pasta Salad**; Temperature Process:** Cold-Holding
Location: 2 door upright at 39 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: soup**; Temperature Process:** Cold-Holding
Location: Walk-in Cooler at 38 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Soup**; Temperature Process:** Hot-Holding
Location: Steam Table at 178 Degrees F.
Comment:
Violation Issued?: No

Bemidji District Office
Minnesota Department of Health
710 5th St NW, Suite A
Bemidji, MN 56601

Sanitizer Observations/Recordings

Establishment Info

The Pillars of Grand Rapids
GRAND RAPIDS
County/Group: Itasca County

Inspection Info

Report Number: F7939251049
Inspection Type: Full
Date: 6/10/2025
Time: 12:06:21 PM

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