Electronically Delivered

March 26, 2026

Licensee
Willows Bend
6455 University Avenue Northeast
Fridley, MN 55432

RE: Project Number(s) SL38980016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 20, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

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

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

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

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

The correction order documentation should include the following:

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

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

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

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

factor.

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Kelly Thorson

Kelly Thorson, Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38980	A. BUILDING: _____ B. WING _____	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS BEND	6455 UNIVERSITY AVENUE NE FRIDLEY, MN 55432

(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: SL38980016-0 On February 16, 2026, through February 20, 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 122 residents; 61 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.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated February 19, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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

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0 510	Continued From page 4 The findings include: During the entrance conference on February 17, 2026, at 11:42 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided assistance with ADLs (activities of daily living) and medication management to residents at the facility. ULP-E ULP-E was hired on March 24, 2025, to provide direct care services to residents. ULP-E's EduCare (online training platform) Transcript indicated ULP-E completed training on personal cares dated March 26, 2025, and infection control techniques dated January 29, 2026. ULP-F ULP-F was hired on May 19, 2025, to provide direct care services to residents. ULP-F's EduCare (online training platform) Transcript indicated ULP-F completed training on personal cares dated June 4, 2025, and infection control techniques dated January 28, 2026. ULP-I ULP-I was hired on February 19, 2024, to provide direct care services to residents. On February 18, 2026, at 7:12 a.m., the surveyor observed ULP-I assist R13 with cares and medication administration. Without performing hand hygiene, ULP-E entered R13's room and applied gloves. ULP-I then assisted R13 to the bathroom and removed R13's urine soiled brief and assisted R13 to the toilet. Then ULP-I obtained clean clothes from R13's closet and	0 510		

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0 510	Continued From page 5 assisted R13 with dressing their lower half of body. ULP-I then put R13's shoes on their feet. ULP-I then removed R13's nightgown, assisted with washing R13's upper-body and putting on a clean sweater. ULP-I then provided peri-care to R13. Without performing hand hygiene, ULP-I changed gloves, then assisted R13 with pulling up a clean brief and pants. ULP-I then escorted R13 to breakfast, disposed of R13's trash, and then ULP-I removed gloves and washed hands. On February 18, 2026, at 7:36 a.m., the surveyor observed ULP-I assist R14 with cares and medication administration. ULP-I performed hand hygiene, applied gloves, administered medications to R14, then assisted R14 to the bathroom. ULP-I removed a bowel movement (BM) soiled brief, without changing gloves ULP-I then removed a medicated transdermal patch from R14's right upper back, then applied a new patch to left upper back. ULP-I placed the old patch in empty wrapper for disposal, then changed gloves, and without performing hand hygiene ULP-I assisted R14 with putting on a clean brief, pants, and shirt while sitting on toilet. ULP-I then provided peri care to R14, and set BM filled wipes and soiled gloves on bathroom floor. ULP-I then performed hand hygiene and applied new gloves. ULP-I assisted R14 to wash face. ULP-I removed gloves, without performing hand hygiene ULP-I applied new gloves and removed R14's bedding and made bed with clean bedding, ULP-I then removed gloves, preformed hand hygiene, and escorted R14 to the dining room. ULP-I returned to R14's room and without performing hand hygiene put on new gloves. ULP-I picked up trash and disposed of it, then removed gloves and performed hand hygiene. On February 18, 2026, at 8:17 a.m., the surveyor	0 510		

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0 510	Continued From page 6 observed ULP-E and ULP-G assist R15 with morning cares. Without performing hand hygiene, ULP-E and ULP-G entered R15's room, applied gloves, and assisted R15 to pivot transfer from bed to wheelchair and then wheelchair to toilet. ULP-E removed R15's urine soiled brief and assisted R15 with washing and dressing R15's upper body. ULP-G and ULP-E assisted R15 to stand, ULP-E provided peri-care and without changing gloves, ULP-E applied a clean brief on R15 and raised R15's pants. Without performing hand hygiene, ULP-E changed gloves and assisted R15 to brush teeth and comb hair at the sink. ULP-E then removed gloves, performed hand hygiene, and escorted R15 to the dining room for breakfast. On February 18, 2026, at 11:49 a.m., ULP-E stated ULP-E was trained to perform hand hygiene before and after all cares, in between glove changes, and when going from dirty to a clean task. ULP-E further stated ULP-E forgot to put hand sanitizer in ULP-E's pocket to use between glove changes. On February 20, 2026, at 12:29 p.m., clinical nurse supervisor (CNS)-B stated staff were expected to perform hand hygiene before and after cares with each resident, after removing gloves, and between glove changes. CNS-B further stated staff were trained to remove or change gloves when after removing a soiled brief or soiled clothing and when moving from a dirty to clean task. The licensee's Standard Infection Control Precautions policy revised on August 1, 2021, indicated staff washed hands after touching blood, body fluids, or contaminated items, before putting gloves on, immediately after gloves were	0 510		

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0 510	Continued From page 7 removed, as necessary between tasks with the same client to prevent cross-contamination, and between all client contacts. The policy further indicated that staff wore gloves when touching blood, body fluids, feces, non-intact skin, or contaminated items, that gloves were changed between tasks with the same client after contact with anything that may contain a high concentration of microorganisms and gloves were removed promptly after use, before touching non-contaminated items, environmental surfaces, self, or other residents. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or 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	0 775		

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0 775	Continued From page 8 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 2-18-26, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) 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 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	0 810		

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0 810	Continued From page 9 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 Environment Inspection Report (PEIR) dated 2-18-26, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One	0 810		

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0 810	Continued From page 10 (21) Days.	0 810		
01780 SS=D	144G.71 Subd. 10 Medication management for residents who will (a) An assisted living facility that is providing medication management services to the resident must develop and implement policies and procedures for giving accurate and current medications to residents for planned or unplanned times away from home according to the resident's individualized medication management plan. The policies and procedures must state that: (1) for planned time away, the medications must be obtained from the pharmacy or set up by the licensed nurse according to appropriate state and federal laws and nursing standards of practice; This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to implement policies and procedure for medication management for a resident with planned time away from home, as required for one of one resident (R4) reviewed. 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:	01780		

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(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
01780	Continued From page 11 During the entrance conference on February 17, 2026, at 11:42 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility. R4 was admitted to the licensee on July 25, 2025, and began receiving assisted living services. R4's diagnoses included dementia, diabetes, hypertension (elevated blood pressure), and chronic kidney disease (progressive loss of ability to filter waste). R4's Service Plan Agreement signed on December 13, 2025, indicated R4 received assistance with bathing, dressing, grooming and oral care reminders, meals, medication management, diabetic management, housekeeping and laundry. R4's Medication Sheet (electronic medication administration record (eMAR)) dated December 1, 2025, through December 31, 2025, indicated R4 received scheduled medications as prescribed on December 1, 2025, through December 8, 2025, before the medications were placed on hold for R4's planned leave of absence (LOA). R4's Progress Notes for [R4] lacked documentation of resident's LOA with family which started on December 8, 2026. R4's record lacked the following documentation as required according to policy: - name of individual who received the medications; - time and date medications were given to the resident or resident representative; and - name and title of the staff member who provided	01780		

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	38980	A. BUILDING: _____ B. WING _____	02/20/2026

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01780	Continued From page 12 the medications to the resident or their representative. On February 18, 2026, at 3:50 p.m., registered nurse (RN)-D stated when a resident left the facility for a LOA, a progress note was entered into the resident's record which indicated who medications were given to for the LOA period and a medication list is provided. RN-D further stated medication supplies were not counted prior to dispensing for LOA and a signature of receipt of medications was not requested from the receiving person. On February 20, 2026, at 12:20 p.m., clinical nurse supervisor (CNS)-B stated staff were expected to document on a medication disposition form the name and dose of medication, quantity of medication, and who the medication was handed to for the resident's LOA. CNS-B further stated a signature from the person who received the medication supply was also required. CNS-B stated the licensee's policy was not followed and education was going to be provided. The licensee's Medications Management- Client Away From Home policy revised August 1, 2021, indicated when the registered nurse (RN) determined original medication containers were safe to send with a resident or the resident's representative, the person who gave the medication to the resident's representative documented who received the medications, the time and date, the quantity or medication in the container and the name and title of the staff person who gave the medications to the resident's representative. No further information was provided.	01780		

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01780	Continued From page 13 TIME PERIOD FOR CORRECTION: Seven (7) days	01780		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure current written or electronically recorded prescriptions were obtained for one of three residents (R3) who received medication management services. 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 February 17, 2026, at 11:42 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility. R3 was admitted to the licensee on March 26, 2025, and began receiving assisted living	01820		

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01820	Continued From page 14 services. R3's diagnoses included dementia, diabetes, and hyperlipidemia (high fat levels in the blood). R3's Service Plan Agreement dated November 14, 2025, indicated R3's services included medication management, blood glucose monitoring four times daily, insulin administration three times daily, meals, laundry, and housekeeping. On February 17, 2026, at 4:41 p.m., the surveyor observed unlicensed personnel (ULP)-I check R3's blood glucose and administer scheduled insulin. R3's Medication Sheet (electronic medication administration record) dated February 2026, indicated R3 received Memantine 10 milligrams (mg) daily and Lantus Solostar 100 unit/milliliter (u/mL) daily. R3's record included an After Visit Summary dated November 6, 2025, which included the above medications however, lacked provider authentication. On February 18, 2026, at 10:02 a.m., clinical nurse supervisor (CNS)-B stated an after-visit summary document is not valid for orders unless signed by the provider. CNS-B further stated CNS-B was not aware an order was accepted without provider signature and that staff would receive re-education about this requirement. The licensee's Medication Management Services policy revised August 1, 2021, indicated [licensee] required a prescription for all scheduled and as needed medications that were managed by the	01820		

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01820	Continued From page 15 licensee. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to date time-sensitive medications with opened and expiration dates for three of five medication storage compartments (dementia care med (medication) cart, med cart two, and med cart four), whose medications were stored by the licensee. In addition, the licensee failed to monitor for expired medications for two of five medication storage compartments. (dementia care med cart and medication overflow closet). 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	01890		

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01890	Continued From page 16 a large portion or all of the residents). The findings include: During the entrance conference on February 17, 2026, at 11:42 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility. TIME SENSITIVE MEDICATIONS On February 17, 2026, at 4:58 p.m., the surveyor observed med cart two with unlicensed personnel (ULP)-I and observed the following: - R12's Advair HFA 230 micrograms (mcg)/21 mcg inhaler was not labeled with date opened and expiration date. On February 17, 2026, at 5:23 p.m., the surveyor observed dementia care med cart with ULP-F and observed the following: - R4's Novolog (fast-acting insulin) 100 units/milliliter (u/ml) FlexPen was not labeled with date opened and expiration date; - R4's Lantus (long-acting insulin) 100 u/ml Solostar was not labeled with date opened and expiration date; and - R10's timolol maleate (decreases high eye pressure) 0.5% ophthalmic solution was not labeled with date opened and expiration date. On February 18, 2026, at 10:42 a.m., the surveyor observed med cart four with ULP-F and observed the following: - R7's Novolog 100 u/ml FlexPen was not labeled with date opened and expiration date. EXPIRED MEDICATIONS On February 17, 2026, at 5:23 p.m., the surveyor observed dementia care med cart with ULP-F and observed the following:	01890		

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01890	Continued From page 17 - R11's latanoprost (decrease high eye pressure by draining fluid) 0.005% ophthalmic solution was labeled with an opened date of December 7, 2025. On February 18, 2026, at 10:14 a.m., the surveyor observed overflow medication closet with registered nurse (RN)-D and observed the following: - R8's Refresh Optive Mega-3 (lubrication) eye drops which expired in September 2025; and - R9's albuterol sulfate 90 mcg/actuation inhalation aerosol which expired May 31, 2025. On February 17, 2026, at 5:24 p.m., ULP-F stated nursing staff audited medication carts weekly and insulin pens were required to be labeled with resident information and the date opened. ULP-F further stated the rights of medication administration were unable to be completed without the previously mentioned required information and that R4 was on leave of absence (LOA) from the facility since December 8, 2025. On February 17, 2026, at 5:37 p.m., clinical nurse supervisor (CNS)-B stated time sensitive medications required a resident label as well as being labeled with the date opened and expiration date. CNS-B further stated nursing staff completed medication cart and overflow medication storage audits weekly and missed the above listed items. On March 19, 2026, at 11:08 a.m., pharmacist (P)-J stated pharmacy resource used by P-J indicated an Advair HFA inhaler expired 1 year from date it was dispensed by pharmacy or when the actuation counter read zero, whichever was sooner.	01890		

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01890	Continued From page 18 The manufacturer instructions for Novolog 100 u/ml dated October 2021, directed to discard 28 days after opening. The manufacturer instructions for Lantus 100 u/ml revised June 2022, directed to discard 28 days after opening. The manufacturer instructions for timolol maleate 0.5% ophthalmic solution issued June 2020, directed to discard remaining contents four weeks after being opened. The manufacturer instructions for latanoprost 0.005% ophthalmic solution revised September 2020, directed to discard remaining contents six weeks after being opened. The licensee's Storage of Medication and Key Security policy revised April 19, 2023, indicated when secured storage of medication is necessary, the nurse identified where medications were to be stored, how they will be secured or locked under proper temperature controls and who had access to the medication. The policy did not address storage of time sensitive medication. The licensee's Medication Administration: Inhaled from a Metered-Dose Inhaler (MDI) revised February 2, 2025, indicated when a new inhaler is opened, the current date and initials of person opening the medication were to be written on the medication. The licensee's Disposition of Medication/Legend and Controlled Substances policy reviewed December 2, 2020, indicated medication supplies which remained at time of resident death or were discontinued were destroyed according to Board	01890		

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01890	Continued From page 19 of Pharmacy regulations. The policy did not address destruction of expired medication. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
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 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	01940		

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01940	Continued From page 20 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 (R5) who had treatments or therapies managed by the licensee. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: During the entrance conference on February 17, 2026, at 12:04 p.m., clinical nurse supervisor (CNS)-B stated the licensee provided treatment and therapy services to residents at the facility. R5 was admitted to the licensee on March 20, 2024, and began receiving assisted living services. R5's diagnoses included Alzheimer's disease, atrial fibrillation (rapid and irregular heart rhythm), osteoporosis (bone structure loses density and becomes porous), and glaucoma (disease that damages the optic nerve in the eye). R5's Service Plan Agreement dated December 5, 2025, indicated R5's services included dressing,	01940		

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01940	Continued From page 21 bathing, grooming, medication management, meals, housekeeping and laundry. R5's record included a verbal order dated December 24, 2025, which indicated R5 was to receive a soft diet. R5's record included a progress note dated December 24, 2025, and written at 12:42 p.m., by registered nurse (RN)-K, which read RN-K received verbal order from hospice provider to change R5's diet to minced and moist IDDSI (International Dysphagia Diet Standardization Initiative) level five due to the choking episode R5 experienced earlier the same day. R5's record lacked a written statement of the treatment provided on R5's service plan. R5's record also lacked a treatment plan including the following required information: - documentation of specific resident instructions related to minced and moist diet order; - procedures for notifying a RN when a problem arose with the oxygen; and - resident-specific requirements relating to documentation of treatment received, verification that all treatment or therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On February 18, 2026, at 8:45 a.m., the surveyor observed unlicensed personnel (ULP)-E escort R5 to the dementia care dining room and served R5's minced and moist breakfast as prepared by the licensee's kitchen. On February 19, 2026, at 9:40 a.m., RN-D stated when a new order is entered or a service is changed on a resident's chart, the resident's	01940		

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01940	Continued From page 22 profile will be marked 'new' and require staff assigned to the resident to read and acknowledge awareness and understanding of the updated information. RN-D further stated resident diet order was listed on the resident's face sheet. On February 19, 2026, at 10:43 a.m., after the start of survey, the provider received a signed physician order from R5's hospice provider, which indicated R5 was to receive minced and moist diet with thin liquids. On February 19, 2026, at 11:48 a.m., CNS-B stated facility nursing staff was expected to obtain a physician's signature for any verbal orders received as soon as possible as well as update the resident service plan and develop treatment management plan for treatment orders. CNS-B further stated the licensee's nursing staff neglected to follow up on R5's verbal order for specialized diet and didn't update the service plan or treatment plan to reflect the new order. The licensee's Medication and Treatment Implementation policy revised on August 1, 2021, indicated upon receipt of a new order from an authorized prescriber, the RN added the order to the resident record, updated the service plan, care plan, or other documents as necessary to reflect the new order. The policy further indicated that an RN took necessary steps to obtain the prescriber's signature on any verbal order as soon as possible and documented efforts to obtain the necessary signature. The licensee's Service Plan Agreement Development and Revision policy revised August 1, 2021, indicated a resident's service plan was reviewed by the RN when changes were needed to the services provided following the receipt of a	01940		

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01940	Continued From page 23 new order from the resident's prescribing provider. 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 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 services were administered as prescribed, resulting in a treatment error, for one of three residents (R5) 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) 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).	01960		

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01960	Continued From page 24 The findings include: R5 was admitted to the licensee on March 20, 2024, and began receiving assisted living services. R5's diagnoses included Alzheimer's disease, atrial fibrillation (rapid and irregular heart rhythm), osteoporosis (bone structure loses density and becomes porous), and glaucoma (disease that damages the optic nerve in the eye). R5's Service Plan Agreement dated December 5, 2025, indicated R5's services included dressing, bathing, grooming, medication management, meals, housekeeping and laundry. R5's record included a verbal order dated December 24, 2025, which indicated R5 was to receive a soft diet. On December 24, 2025, at 12:42 p.m., registered nurse (RN)-K entered a progress note into R5's record which indicated RN-K received a verbal order from hospice provider to change R5's diet to minced and moist IDDSI (International Dysphagia Diet Standardization Initiative) level five due to the choking episode R5 experienced earlier the same day. On January 4, 2026, at 3:52 p.m., RN-L entered a progress note into R5's record which indicated R5 experienced a choking episode after R5 consumed half of a peanut butter and jelly sandwich. On February 18, 2026, at 8:45 a.m., the surveyor observed unlicensed personnel (ULP)-E escort R5 to the dementia care dining room and served	01960		

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WILLOWS BEND	6455 UNIVERSITY AVENUE NE FRIDLEY, MN 55432

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01960	Continued From page 25 R5's minced and moist breakfast as prepared by the licensee's kitchen. On February 19, 2026, at 1:11 p.m., assisted living director in residency (ALDIR)-A stated facility leadership recognized a gap in communication between nursing and activities departments which resulted in R5 receiving a snack which did not follow treatment order. ALDIR-A further acknowledged when staff don't follow a resident's care plan that constituted caregiver neglect. Level 5 Minced and Moist Food for Adults guidelines from the International Dysphagia Diet Standardization Initiative dated January 2019, indicated an adult who required a minced an moist diet should not be served regular dry bread or nut butter due to high choking risk. The licensee's Medication and Treatment Implementation policy revised August 1, 2021, indicated a RN updated resident record and service as necessary to reflect a new treatment order and the RN was responsible for assuring the order was implemented appropriately. 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	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38980	A. BUILDING: _____ B. WING _____	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS BEND	6455 UNIVERSITY AVENUE NE FRIDLEY, MN 55432

(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
01970	Continued From page 26 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 (R3) who received treatments managed by the provider. This practice resulted in a level two violation (a violation that did not harm a client'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 February 17, 2026, at 12:04 p.m., clinical nurse supervisor (CNS)-B stated the licensee provided treatment and therapy services to residents at the facility. R3 was admitted to the licensee on March 26, 2025, and began receiving assisted living services. R3's diagnoses included dementia, diabetes, and hyperlipidemia (high fat levels in the blood). R3's Service Plan Agreement dated November 14, 2025, indicated R3's services included medication management, blood glucose	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38980	A. BUILDING: _____ B. WING _____	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS BEND	6455 UNIVERSITY AVENUE NE FRIDLEY, MN 55432

(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
01970	Continued From page 27 monitoring four times daily, meals, laundry, and housekeeping. R3's Basic Assessment/ULP (unlicensed personnel) Services dated February 12, 2026, indicated licensee's ULPs performed blood glucose checks on R3 four times daily. R3's Service Checkoff List dated February 2026 indicated R3's blood glucose level was checked and documented daily at 8:00 a.m., 11:45 a.m., 4:45 p.m., and 8:00 p.m. R3's record lacked a signed prescriber order to monitor R3's blood glucose levels four times daily. On February 17, 2026, at 4:41 p.m., the surveyor observed ULP-I check R3's blood glucose and administer scheduled insulin. On February 19, 2026, at 10:02 a.m., CNS-B stated the licensee received a new order to monitor R3's glucose four times daily however the order was not put into R3's chart and must have been misplaced. The licensee's Medication and Treatment Implementation policy revised on August 1, 2021, indicated upon receipt of a new order from an authorized prescriber, the RN added the order to the resident record, updated the service plan, care plan, or other documents as necessary to reflect the new order. The policy further indicated that an RN took necessary steps to obtain the prescriber's signature on any verbal order as soon as possible and documented efforts to obtain the necessary signature. No further information was provided.	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38980	A. BUILDING: _____ B. WING _____	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS BEND	6455 UNIVERSITY AVENUE NE FRIDLEY, MN 55432

(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
01970	Continued From page 28 TIME PERIOD FOR CORRECTION: Seven (7) days	01970		

St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Willows Bend
6455 University Avenue NE
Fridley, MN 55432
Anoka County
Parcel:

Phone:

License Info

License: HFID 38980

Risk:
License:
Expires on:
CFPM: Douglas J. Pitterman
CFPM #: 106333; Exp: 12/30/2026

Inspection Info

Report Number: F1051261036
Inspection Type: Full - Single
Date: 2/18/2026 Time: 11:00:00 AM
Duration: 45 minutes
Announced Inspection: No
Total Priority 1 Orders: 1
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

! New Order: 4-500 Equipment Maintenance and Operation

4-501.114C3 *Priority Level: Priority 1 CFP#: 16*

MN Rule 4626.0805C3 Provide and maintain an approved quaternary ammonium compound sanitizing solution in water with 500 ppm hardness or less, a minimum temperature of 75 degrees F (24 degrees C) and a concentration specified in 21CFR.178.1010 and as indicated by the manufacturer's use directions and label.

COMMENT:
AT THE TIME OF INSPECTION, THE QUAT DISPENSER AT THE KITCHEN 3-COMPARTMENT SINK MEASURED 100 PPM. CONTACT THE SANITIZER COMPANY TO RESERVICE THE DISPENSER.

Comply By: 2/18/2026 Originally Issued On: 2/18/2026

Food & Beverage General Comment

MET WITH THE NURSE SURVEYOR, ALLISON SKILLINGSTAD

DISCUSSED THE FOLLOWING WITH THE FOOD CULINARY DIRECTOR, DOUGLAS:

EMPLOYEE ILLNESS LOG
VOMIT CLEAN-UP PROCEDURES
HANDWASHING AND GLOVE USE/DISPOSAL
NOROVIRUS

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 St Cloud District Office inspection report number F1051261036 from 2/18/2026

Douglas Pitterman
Food Culinary Director

Kai Yang,
Public Health Sanitarian 1
320-640-3532
kai.yang@state.mn.us

St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301

Temperature Observations/Recordings

Establishment Info

Willows Bend
Fridley
County/Group: Anoka County

Inspection Info

Report Number: F1051261036
Inspection Type: Full
Date: 2/18/2026
Time: 11:00:00 AM

Food Temperature: Product/Item/Unit: SLICED HAM**; Temperature Process:** Cold-Holding
Location: Cold Line at 39 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: SLICED TURKEY**; Temperature Process:** Cold-Holding
Location: Cold Line at 38 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: CUT LETTUCE**; Temperature Process:** Cold-Holding
Location: Cold Line at 40 Degrees F.
Comment:
Violation Issued?: No

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

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

Food Temperature: Product/Item/Unit: MILK**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 40 Degrees F.
Comment: MEMORY CARE
Violation Issued?: No

Food Temperature: Product/Item/Unit: SPANISH RICE**; Temperature Process:** Cold-Holding
Location: Walk-in Cooler at 39 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: CUT TOMATOES**; Temperature Process:** Cold-Holding
Location: Walk-in Cooler at 39 Degrees F.
Comment:
Violation Issued?: No

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

St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301

Sanitizer Observations/Recordings

Establishment Info

Willows Bend
Fridley
County/Group: Anoka County

Inspection Info

Report Number: F1051261036
Inspection Type: Full
Date: 2/18/2026
Time: 11:00:00 AM

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** Dispenser
Location: 3-Comp Sink **Equal To** 100 PPM
Comment:
Violation Issued?: Yes

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Dishwashing Area **Equal To** 170 Degrees F.
Comment:
Violation Issued?: No

Minnesota (MDH) Version
EH Manager; RPT: F1051261036

Food Establishment Inspection Report

St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301

No. of Risk Factor/Intervention/Violations	1	Date: 2/18/2026
No. of Repeat Risk Factor/Intervention/Violations		Time: 11:00 AM
Score (optional)		Dur: 45 min

Establishment:	Address:	City/State:	Zip:	Phone:
Willows Bend	6455 University Avenue NE	Fridley, MN	55432	
License/Permit #:	**Permit Holder:**	**Purpose of Inspection:**	**Est. Type:**	**Risk Category:**
HFID 38980		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	OUT	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	N/O	Proper cooking time & temperatures		
19	N/O	Proper reheating procedures for hot holding		
20	N/O	Proper cooling time and temperature		
21	N/O	Proper hot holding temperatures		
22	IN	Proper cold holding temperatures		
23	IN	Proper date marking & disposition		
24	N/A	Time as public health control;procedures & record		
	Consumer Advisory			
25	N/A	Consumer advisory provided for raw or undercooked foods		
	Highly Susceptible Populations			
26	N/A	Pasteurized foods used; prohibited foods not offered		
	Food/Color Additives and Toxic Substances			
27	N/A	Food additives; approved & properly used		
28	N/A	Toxic substances properly identified;stored;used		
	Conformance with Approved Procedures			
29	N/A	Compliance with variance, specialized processes & HACCP plan		

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

GOOD RETAIL PRACTICES

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

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

			COS	R
		Safe Food and Water		
30	IN	Pasteurized eggs used where required		
31		Water & ice from approved source		
32	N/A	Variance obtained for specialized processing methods		
		Food Temperature Control		
33		Proper cooling methods used; adequate equipment for temperature control		
34	N/O	Plant food properly cooked for hot holding		
35	IN	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) Blai Yang

Follow-up: Follow-up Date:

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL38980016-0	**Date:** 2/18/2026
Facility Name: WILLOWS BEND	
Facility Address: 6455 UNIVERSITY AVENUE NE FRIDLEY, MN 55432	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Twenty One (21) 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. Fire doors shall be maintained to be self-closing and latch as designed. Fire doors shall not be blocked, obstructed, or otherwise made inoperable. [Minn. Stat. 144G.45 subd. 2; MSFC 705]

Comments: The fire-rated doors in the following locations did not close and latch: resident room 245 and the south stairwell door to garage parking.

The second floor nursing station office was held open with a rubber wedge.

3. Gas fired commercial cooking appliances installed on casters and appliances that are moved for cleaning and sanitation purposes shall be connected to the piping system with a connector complying with ANSI Z21.69. Movement of appliances on casters shall be limited by a restraining device installed in accordance with the connector and appliance manufacturer's instructions. [Minn. Stat. 144G.45 subd. 2; MSFC 607.4]

Comments: In the kitchen facilities, the cooking appliances (deep fryer, stove top) are not connected with a restraining device. Restraining devices were present but not attached.

DEPARTMENT OF HEALTH

☒ **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 that include the location and number of resident rooms. [Minn. Stat. 144G.45 subd.2]

   Comments: Posted throughout the facility and in the facilities Fire Safety and Emergency Policy's (FSEP) the emergency egress maps did not direct residents, staff or visitors to egress locations.