Electronically Delivered

November 10, 2025

Licensee
Lindstrom Senior Living
30455 Lehigh Avenue
Lindstrom, MN 55045

RE: Project Number(s) SL37816016

Dear Licensee:

On October 30, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on August 6, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Kelly Thorson

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

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September 22, 2025

Licensee
Lindstrom Senior Living
30455 Lehigh Avenue
Lindstrom, MN 55045

RE: Project Number(s) SL37816016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 6, 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.

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 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00
St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,500.00**. 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,

Kelly Thorson

Kelly Thorson, Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.us
Telephone: 320-223-7336 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
	37816	A. BUILDING: _____ B. WING _____	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINDSTROM SENIOR LIVING	30455 LEHIGH AVENUE LINDSTROM, MN 55045

(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: SL37816016 On August 4, 2025, through August 6, 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 87 residents; 82 receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. 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 surveyors' 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 subd. 1, 2, and 3.	
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an	0 630		

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0 630	Continued From page 1 individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed or included a review/assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults and statements of the specific measures to be taken to minimize the risk of abuse for one of one resident (R2). 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: R2 admitted to licensee on May 5, 2025, as a housing only resident.	0 630		

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0 630	Continued From page 2 R2's individual abuse prevention plan (IAPP) lacked a review/assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults and statements of the specific measures to be taken to minimize the risk of abuse. On August 4, 2025, at 2:45 p.m. clinical nurse supervisor (CNS)-C stated the IAPP was not completed for R2 but that IAPP's were completed for all the other residents. That one was just missed. The licensee's Initial and On-Going Nursing Assessment of Assisted Living Residents policy dated October 2022, indicated an RN will complete a nursing assessment of each assisted living resident on or before the date the resident moves in or signs an assisted living contract. Residents who do not require assisted living services per statute 144G.08 subd. 9 do not require a nursing assessment. An "Individual Review" within the EMR will be completed for any resident not receiving assisted living services. The Individual Review will be completed by the RN and will be used to generate an Individual Abuse Prevention Plan which is a regulatory requirement for any resident residing in a licensed assisted living facility. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment	0 775		

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0 775	Continued From page 3 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) 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). Findings include: On a facility tour on August 05, 2025, from 11:20 a.m. to 12:20 p.m., with maintenance (M)-E, the surveyor made the following observations of non-compliance with the requirements of the Minnesota State Fire Code (MSFC) in Minnesota Rules Chapter 7511: EXIT DOOR LOCKING ARRANGEMENTS There was a controlled egress locking system installed on the emergency exit door in the memory care unit leading to the exterior exit path. The controlled egress door locking system was not provided with a device capable of deactivating the delayed egress door hardware to the unlocked position from the nurse station or other approved location for occupants to exit in the event of an emergency. The controlled egress locking system is required	0 775		

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0 775	Continued From page 4 to be provided with a switch or device located at the nurse station or other approved location to deactivate the delayed egress locked exit doors for building occupants to exit in the event of an emergency. The procedures required to operate and unlock the controlled egress locking system for occupants to exit in the event of an emergency are required to be included in the fire safety and evacuation plan employee procedures. These procedures are required in accordance with MSFC in Minnesota Rules Chapter 7511. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive 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	0 810		

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0 810	Continued From page 5 their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. 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) 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 August 04, 2025, at 12:45 p.m., licensed assisted living director in residency (LALDIR)-B and licensed assisted living director (LALD)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the	0 810		

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0 810	Continued From page 6 facility. The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Record review of licensee's evacuation drill log indicated evacuation drills were conducted for the month of July 2025. LALD-A stated that the facility has had a change in management and staff the past six months and is trying to get on track with all of the evacuation drill requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was	01290		

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01290	Continued From page 7 submitted and completed for the current health facility identification (HFID) number for one of one employee (unlicensed personnel (ULP-D) on the facility provided employee roster. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). This resulted in an immediate correction order issued on August 5, 2025. The findings include: On August 4, 2025, at 12:10 p.m., the surveyor reviewed the facility's NetStudy 2.0 roster and compared it to the facility's staff roster and discovered one of the facility's employees was not listed as having a background study submitted with the licensee's HFID 37816. ULP-D was hired on May 28, 2025, to provide direct care and services to the licensee's residents. ULP-D provided direct care services without direct supervision on July 8, 9, and 10, 2025. A background study had not been completed for ULP-D. On August 4, 2025, at 2:30 p.m., licensed assisted living director (LALD)-A stated they were between staffing specialists at the time and ULP-D slipped through the cracks. Our regular procedure for new staff is to run the background study during onboarding and they are not	01290		

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01290	Continued From page 8 released from training until they are cleared. The licensee's Background Studies policy last reviewed June 2025, indicated [the facility] is required to conduct background studies and provide fingerprints for all new hires through Net Study 2.0 and IDEMIA. The study subject will work only under supervision until clearance is received from Net Study 2.0 No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	01290		
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 interview and record review, the licensee failed to maintain current medication orders for one of three residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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:	01820		

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01820	Continued From page 9 R3's service plan, dated June 27, 2025, indicated R3 received medication administration services. R3's medication administration record (MAR) dated August 2025, included the following scheduled medications: -levothyroxine 50mcg, take one tablet by mouth daily -lidocaine 4% pain relief patch, place 1 patch to low back in the morning, remove at bedtime -lisinopril 40mg, take one tablet by mouth daily -valacyclovir 1 gram tab, take one tablet by mouth three times daily for 7 days- starts 8/1/25 R3's record included signed provider orders dated June 27, 2025, for the following medications: -ascorbic acid 100mg by mouth daily for vitamin supplementation -ginkgo biloba 40mg 1 tab by mouth daily for vitamin supplementation -levothyroxine 50mcg by mouth daily for hypothyroid -lisinopril 40mg by mouth daily for hypertension -multivitamin 1 cap by mouth daily for vitamin supplementation -omega 3 (cod liver oil) 1 cap by mouth daily for vitamin supplementation -vitamin E 400u 1 cap by mouth daily for vitamin supplementation -vitamin D 1000u by mouth every morning R3's record included an unsigned after visit summary for the following medications: -lidocaine 4% patch place 1 patch onto the skin every 24 hours for 12 hours	01820		

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01820	Continued From page 10 -valacyclovir 1000mg tablet, take 1 tablet by mouth 3 times daily for 7 days On August 6, 2025, at 11:35 a.m., clinical nurse supervisor (CNS)-C stated they know after visit summaries are not signed provider orders and will remind the other nurses of this and will make sure they get signed orders. CNS-C further stated R3's son asked to have all her vitamins put on hold, but they do not have provider orders for this. The licensee's Implementation and Renewal of Medication Prescriptions, Treatment and Therapy Orders policy dated January 2024, indicated the RN or Licensed Health Professional will take necessary steps to obtain the prescriber's signature on any verbal orders or prescriptions as soon as possible and will document efforts to obtain the necessary signature. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01820		
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable	02310		

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LINDSTROM SENIOR LIVING	30455 LEHIGH AVENUE LINDSTROM, MN 55045

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02310	Continued From page 11 health care and medical, or nursing standards for one of one resident (R3) with an assistive device (consumer side rail). 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 August 5, 2025, at 3:00 p.m. the surveyor, along with licensed assisted living director (LALD)-A and licensed assisted living director in residency (LALDIR)-B observed R3's consumer side rail. The side rail was a large u-shaped bar attached to a board which slid under the mattress and had a strap attached. The surveyor pulled outward on the side rail to check if it was securely attached and was able to pull it out from under the mattress with minimal effort. The side rail was not secured to the bed or bed frame. R3's son was in the room and stated he had installed the side rail and questioned if the strap should have been attached. R3's Bed Rail Informed Consent Form dated March 9, 2025, indicated the device type as consumer rail: manufacturer not on device (unknown) and Consumer Rail: Portable bed rail is installed securely, per manufacturer guidelines, and does not have openings large enough for a resident to become entrapped- box marked N/A unknown.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37816	A. BUILDING: _____ B. WING _____	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINDSTROM SENIOR LIVING	30455 LEHIGH AVENUE LINDSTROM, MN 55045

(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
02310	Continued From page 12 R3's comprehensive nursing assessment dated June 27, 2025, indicated -bed type: standard bed frame -mattress type: mattress original to bed -bed rails in use: partial side rail present in bed. This device is not attached to bed nor an original attachment to the bed. It is a rail that stays in place between mattress and bed frame -describe rationale for bed rails, specify: aid with transfers in/out of bed -do the bed rails function as a restraint: no -is there a high risk for injury if bed rails are in use (cognition): Yes, specify: not regulation rails -is there a history of injury related to bed rails: no -portable bed rails installed and maintained according to manufacturer instructions and the Consumer Product Safety Commission site reviewed for any recalls of this device: no On August 5, 2025, at 3:15 p.m., clinical nurse supervisor (CNS)-C stated unlicensed personnel (ULP) should be checking side rails each time they are in the room and reporting any issues to the nurse, however, this is not a daily task assigned to anyone. Nursing checks the side rails quarterly during the resident 90-day assessment. CNS-C further stated when they complete side rail assessments, they take measurements, go over risks versus benefits with the resident and the resident representative, and they do check the recall list. The family installed the side rails, and the facility verified it was installed correctly. They should have manufacturer's instructions for all consumer side rails but may not have them for all. The Food and Drug Administration (FDA) guidelines titled Recommendations for Health Care Providers about Bed Rails, dated July 9,	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37816	A. BUILDING: _____ B. WING _____	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINDSTROM SENIOR LIVING	30455 LEHIGH AVENUE LINDSTROM, MN 55045

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02310	Continued From page 13 2018, indicated health care providers should base the use of bed rails on individual resident assessments to ensure the individual is an appropriate candidate to reduce the risk of entrapment. Recommendations made for health care providers to evaluate the individual's need, to use the guidance documented "Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment" to have knowledge that not all bed rails, mattresses, and bed frames are interchangeable; check the manufacturer's instructions, health care providers are to avoid the routine use of adult bed rails without first conducting an individual patient or resident assessment, and restrict the use of physical restraints including restrictive use of bed rails, or chest, abdominal, wrist, or ankle restraints of any kind on individuals in bed. When installing and using bedrails, select the appropriate bed rail, follow the health care provider's procedures, or manufacturer's recommendations, inspect, evaluate, and regularly check bedrails are appropriately matched to equipment and patient needs considering all relevant risk factors, to identify and remove potential fall and entrapment hazards. Be aware that gaps can be created by movement or compression of the mattress, which may be caused by patient weight, movement, bed position, or by using a specialty mattress. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently Asked Questions (FAQs) dated June 21, 2023, indicated, "Licensees should review the CSPC website regularly for updates on recalled portable bed rails. The opportune time to do this would be with the 90-day assessment due to the requirement included in the uniform assessment tool for assessing assistive devices and documentation about a resident's bed rails	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37816	A. BUILDING: _____ B. WING _____	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINDSTROM SENIOR LIVING	30455 LEHIGH AVENUE LINDSTROM, MN 55045

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02310	Continued From page 14 includes, but is not limited to: - Purpose and intention of the bed rail - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail - The resident's bed rail use/need assessment - Risk vs. benefits discussion (individualized to each resident's risks) - The resident's preferences - Installation and use according to manufacturer's guidelines - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements." The licensee's Bed Rail/Device Use policy dated July 2022, indicated due to the risk of injury related to the use of physical devices, such devices will only be used after an assessment has been completed to determine the risks and benefits of this use. Staff will alert the RN if an assisted living resident has any type of bed rail or similar equipment and the RN will then evaluate whether the bed rail appears to be appropriate and safe for the resident. The RN will educate the resident and the resident's representative about the risks related to bed rails, and if the resident's bed rail does not appear to meet FDA standards, the RN will recommend to the resident, the resident's representative, the resident's involved family members that the bed rail be removed and will recommend alternative options to reduce resident risk. The RN will document these conversations and recommendations.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37816	A. BUILDING: _____ B. WING _____	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINDSTROM SENIOR LIVING	30455 LEHIGH AVENUE LINDSTROM, MN 55045

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02310	Continued From page 15 Procedure: 1. Staff will be educated to report to a licensed nurse immediately of any new bed device(s) or if an existing device is found to be loose or malfunctioning. Physical devices include, but are not limited to, side rails (half or full); grab bars, halo bars, positioning poles. 2. When notified that a resident, who is receiving assisted living services, has a bed rail, the RN will document the type of rail being used (consumer portable vs hospital-style) and assess the rail for appropriate use and safety, including: a. Portable Consumer Bed Rail- If the resident has a portable consumer bed rail, the RN will: i. Obtain the individual manufacturer's instructions/guidelines for the bed rail in use. If not provided by the resident or family, the RN may download and print the guidelines from the internet. ii. Ensure that the bed rail has not shifted, is securely attached to the bed frame, and is installed per manufacturer recommendations. iii. RN should refer to the Consumer Product Safety Commission (CSPC) for the most up-to-date information related to portable bed side rail recall information. If the device is on the recall list, the RN should immediately notify the resident/and or family and request that the recalled device is removed from use. iv. If the RN is unable to determine who the manufacturer is, a complete assessment for safety cannot be conducted related to the missing installation and maintenance instructions. The lack of this information places resident at risk of injury and should be included in your discussion with the resident and/or responsible party. Recommend alternatives and request the	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37816	A. BUILDING: _____ B. WING _____	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINDSTROM SENIOR LIVING	30455 LEHIGH AVENUE LINDSTROM, MN 55045

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02310	Continued From page 16 resident/responsible party removes the device. If resident or family refuse to remove the device after risk discussion, the RN should consider reporting the case to MAARC. v. Twice a year (if not done routinely with new device implementations), the RN should run the CSPC report to ensure no additional recalled devices have been added to the report. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently Asked Questions (FAQs) dated April 25, 2023, indicated, "Licensees should review the CSPC website regularly for updates on recalled portable bed rails. The opportune time to do this would be with the 90-day assessment due to the requirement included in the uniform assessment tool for assessing assistive devices." No further information was provided. TIME PERIOD FOR CORRECTION: two (2) days	02310		

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

LINDSTROM SENIOR LIVING
30455 LEHIGH AVENUE
Lindstrom, MN 55056
Chisago County
Parcel:

Phone:

License Info

License: HFID 37816

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

Inspection Info

Report Number: F1025251078
Inspection Type: Full - Single
Date: 8/4/2025 Time: 12:30 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

Reported work order in for flight outside of walk-in cooler

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 Metro District Office inspection report number F1025251078 from 8/4/2025

Vicki

Casey Kipping, MA RS
Public Health Sanitarian 3
651-201-4513
casey.kipping@state.mn.us

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Temperature Observations/Recordings

Establishment Info

LINDSTROM SENIOR LIVING
Lindstrom
County/Group: Chisago County

Inspection Info

Report Number: F1025251078
Inspection Type: Full
Date: 8/4/2025
Time: 12:30 PM

New Record: Product/Item/Unit: Rice**; Temperature Process:** Hot-Holding
Location: Steam Table at 155 Degrees F.
Comment:
Violation Issued?: No

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

New Record: Product/Item/Unit: Sliced tomato**; Temperature Process:** Cooling
Location: Prep Cooler at 45 Degrees F.
Comment:
Violation Issued?: No

New Record: Product/Item/Unit: Deli meat**; Temperature Process:** Cold-Holding
Location: Prep Cooler at 39 Degrees F.
Comment:
Violation Issued?: No

New Record: Product/Item/Unit: Soup**; Temperature Process:** Hot-Holding
Location: Kettle at 167 Degrees F.
Comment:
Violation Issued?: No

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Sanitizer Observations/Recordings

Establishment Info

LINDSTROM SENIOR LIVING
Lindstrom
County/Group: Chisago County

Inspection Info

Report Number: F1025251078
Inspection Type: Full
Date: 8/4/2025
Time: 12:30 PM

New Record: **Product:** Dish machine**; Sanitizing Process:** High temp
Location: Dishwashing Area **Equal To**
Comment: 160 deg F
180 R
20 PSI
Violation Issued?: No

New Record: **Product:** Quaternary Ammonia**; Sanitizing Process:**
Location: 3 compartment sink **Equal To**
Comment: 300 PPM
Violation Issued?: No

Minnesota (MDH) Version
EH Manager; RPT: F1025251078

Food Establishment Inspection Report

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

No. of Risk Factor/Intervention/Violations	0	Date: 8/4/2025
No. of Repeat Risk Factor/Intervention/Violations		Time: 12:30 PM
Score (optional)		Dur: min

Establishment:	Address:	City/State:	Zip:	Phone:
LINDSTROM SENIOR LIVING	30455 LEHIGH AVENUE	Lindstrom, MN	55056	
License/Permit #:	**Permit Holder:**	**Purpose of Inspection:**	**Est. Type:**	**Risk Category:**
HFID 37816		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

	Compliance Status		COS	R
	Time/Temperature Control for Safety			
18	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	IN	Pasteurized foods used; prohibited foods not offered		
	Food/Color Additives and Toxic Substances			
27	N/A	Food additives; approved & properly used		
28	IN	Toxic substances properly identified;stored;used		
	Conformance with Approved Procedures			
29	N/A	Compliance with variance, specialized processes & HACCP plan		

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

GOOD RETAIL PRACTICES

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

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

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

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

Person in Charge (signature)

Inspector (signature)

Follow-up: Follow-up Date: