Electronically Delivered

February 11, 2026

Licensee
Diamond Willow Assisted Living
1401 5th Avenue Northeast
Little Falls, MN 56345

RE: Project Number(s) SL25706016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 22, 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,

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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25706	A. BUILDING: _____ B. WING _____	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMOND WILLOW ASSISTED LIVING	1401 5TH AVENUE NE LITTLE FALLS, MN 56345

(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: SL25706016-0 On January 20, 2026, through January 22, 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 25 residents; all 25 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.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the clinical nurse supervisor (CNS) developed and implemented a staffing plan to determine staffing levels to meet the needs of all residents, which included reviewing the staffing plan at least twice per year. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a	0 470		

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0 470	Continued From page 2 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: The licensee held an assisted living facility with dementia care license and was licensed for a capacity of 26 residents. During the entrance conference on January 20, 2026, at 9:53 a.m., CNS/assisted living director in residency (CNS/ALDIR)-A stated the licensee was familiar with the current minimum living requirements. The license's untitled staffing plan was dated November 4, 2025. On January 20, 2026, at 10:52 a.m., regional director (RD)-B stated this was the only available staffing plan as she was not able to locate any documentation from the previous CNS. No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	0 470		
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	0 510		

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0 510	Continued From page 3 nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program to comply with accepted health care, medical, and nursing standards for infection control for two of three employees (unlicensed personnel/ULP-E, ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 January 21, 2026, at 7:30 a.m., the surveyor observed ULP-E perform a blood glucose check on R2. ULP-E gathered her supplies, performed hand hygiene, put on gloves, wiped R2's left pointer finger with an alcohol wipe, poked the finger with a lancet, placed the blood sample on the test strip, and removed the glove from her	0 510		

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0 510	Continued From page 4 right hand. ULP-E then touched the computer to enter the data, gave R2 her pills, opened the cabinet, opened the apartment door, returned the items to the medication cart, and at this time, removed the glove from her left hand and performed hand hygiene. At this time, ULP-E stated she should have done hand hygiene before and after performing the blood glucose check as trained, but there was no hand sanitizer in the apartment. On January 21, 2026, at 8:55 a.m., the surveyor observed ULP-D perform cares for R1. ULP-D performed perineal cares on R1 and placed the used wash rag and towels on the bedside table, put cream on R1's perineal area, changed the glove on her right hand, pulled up the incontinent brief and pants to her knees, put on R1's shoes, removed the nightgown, put on a shirt and sweater, assisted R1 to stand, pulled up her pants, and once R1 was in the chair, ULP-D removed the gloves and washed her hands. Upon exiting the room, ULP-D stated she should not have placed the used towels on the bedside table and should have done hand hygiene after performing perineal cares and before applying the cream. On January 21, 2026, at 10:05 a.m., clinical nurse supervisor/assisted living director in residency (CNS/ALDIR)-A stated staff were expected to perform hand hygiene before and after performing tasks and after removing gloves. CNS/ALDIR-A also said towels should not be placed on the bedside table when dirty. The licensee's Hand Washing policy dated January 1, 2025, noted hand washing should be completed after changing incontinent briefs or cleaning up after someone used the toilet.	0 510		

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0 510	Continued From page 5 The Centers for Disease Control's (CDC), "CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings" dated April 12, 2024, under section 5a.1 indicated: 1.) Require healthcare personnel to perform hand hygiene in accordance with CDC recommendations. 2.) Use an alcohol-based hand rub or wash with soap and water for the following clinical indications: a.) Immediately before touching a patient; b.) Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices; c.) Before moving from work on a soiled body site to a clean body site on the same patient; d.) After touching a patient or the patient's immediate environment; e.) After contact with blood, body fluids or contaminated surfaces; and f.) Immediately after glove removal. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent	0 580		

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0 580	Continued From page 6 services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain documentation of quality management activity programs appropriate to the size and relevant to the type of services provided. 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: During the entrance conference on January 20, 2026, at 9:53 a.m., clinical nurse supervisor/assisted living director in residency (CNS/ALDIR)-A stated the licensee held quarterly quality management meetings. The licensee's Quality Management Activity Template dated August 2025, noted a problem with urinary tract infections with a goal to decrease the number. On January 21, 2026, at 2:00 p.m., regional director (RD)-B stated the above was the only documentation available, and stated she was	0 580		

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0 580	Continued From page 7 unable to locate any meeting minutes from previous employees. The licensee's Quality Management Project policy dated January 1, 2025, noted the licensee would have at least one documented quality management project in place at all times, and would retain records for at least two years. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580		
0 620 SS=E	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. The requirement in Minnesota Statute section 626.557, Subd. 3 is: (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from	0 620		

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0 620	Continued From page 8 another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report an incident	0 620		

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0 620	Continued From page 9 of suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC) for four of eight residents (R2, R5, R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2 R2's diagnoses included depression and hypertension (high blood pressure). R2's record lacked a service plan. The MAARC report noted on December 3, 2025, at 6:00 p.m., R2 went to a bar with her friend. Later, R2's family called the facility to let them know R2 was outside the bar on her hands and knees and they called 911. R2 was taken to the local hospital who reported R2 was not wearing a coat or shoes. The report was submitted to MAARC on December 12, 2026, at 10:22 a.m. On January 22, 2026, at 12:50 p.m., clinical nurse supervisor/assisted living director in residency (CNS/ALDIR)-A stated their Ombudsman representative had called to talk about this and encouraged them to fill out a report. CNS/ALDIR-A stated they were aware of it, but not clear on if it should have been reported or not.	0 620		

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0 620	Continued From page 10 R5 R5's diagnoses included Alzheimer's disease, anxiety disorder, and hypertension. R5's Service Plan dated November 6, 2025, indicated R5 received services including assistance with bathing, dressing, grooming, and medication administration. The MAARC report noted on January 17, 2026, at 7:00 p.m., R5 fell when trying to sit in her wheelchair and was taken to the local hospital where she was diagnosed with a pelvic fracture. The report was submitted to MAARC on January 19, 2026. On January 22, 2026, at 12:52 p.m., CNS/ALDIR-A stated staff had notified the on call nursing service, and he was not aware of the incident until he came in on Monday, when he made the report. R3 R3's diagnoses included atrial fibrillation (rapid, irregular heartbeat), chronic kidney disease, and sleep apnea. R3's Service Plan dated July 18, 2025, indicated R3 received services including assistance with ambulation, bathing, grooming, and medication administration. The MAARC report noted on September 26, 2025, at 3:45 p.m., R3 was taken out of the facility by his wife without informing staff or signing him out. When he returned, staff assisted him with toileting and found dried fecal matter in the incontinent brief and on his skin. The report was submitted to MAARC on October 3, 2025.	0 620		

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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
0 620	Continued From page 11 On January 22, 2026, at 12:55 p.m., CNS/ALDIR-A stated their Ombudsman and the county discussed this with the licensee and it was reported. R4 R4's diagnoses included Alzheimer's disease, depression, and osteoarthritis. R4 lacked a service plan. The MAARC Report noted on September 13, 2025, at 12:36 a.m., R4 was wandering the facility, turned around and tripped, falling on his right side. R4's head was bleeding and was sent to the local hospital. R4 was diagnosed with multiple small pelvic fractures and rib fractures. The report was submitted to MAARC on September 15, 2025, at 10:00 a.m. On January 22, 2026, at 12:58 a.m., CNS/ALDIR-A stated the on call nursing service had not notified him of this incident, and he reported it when he found out. CNS/ALDIR-A stated he would need to speak to the on call nursing service about reporting incidents to him immediately. The licensee's Vulnerable Adult Maltreatment - Prevention & Reporting policy dated January 1, 2025, noted maltreatment must be reported no later than 24 hours after the maltreatment was first suspected. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		

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	25706	A. BUILDING: _____ B. WING _____	01/22/2026

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DIAMOND WILLOW ASSISTED LIVING	1401 5TH AVENUE NE LITTLE FALLS, MN 56345

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0 630	Continued From page 12	0 630		
0 630 SS=E	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1's diagnoses included hypertension (high blood pressure), arthritis, and Parkinsonism (a group of	0 630		

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0 630	Continued From page 13 neurological disorders causing slowness, stiffness, tremor, and postural instability). On January 21, 2026, at 7:55 a.m., the surveyor observed unlicensed personnel (ULP)-D administer medications to R1 in her room. R1's Assessment dated December 30, 2025, noted R1 received assistance with bathing, dressing, hygiene, mobility, toileting, and medication administration. It also noted a R1 was susceptible to abuse by others. However, it lacked an assessment of R1's risk of abusing other vulnerable adults. R1's record lacked a service plan. R2 R2's diagnoses included depression and hypertension (high blood pressure). On January 21, 2026, at 7:30 a.m., the surveyor observed ULP-E perform a blood glucose check and medication administration to R2. R2's Assessment dated December 7,2025, noted R2 received assistance with bathing, dressing, hygiene, mobility, toileting, and medication administration. It also noted a R2 was susceptible to abuse by others. However, it lacked an assessment of R2's risk of abusing other vulnerable adults. R2's record lacked a service plan. On January 21, 2026, at 1:05 p.m., clinical nurse supervisor/assisted living director in residency (CNS/ALDIR)-A stated this was not included in the assessments for R1 and R2, and he would contact the electronic record company for	0 630		

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0 630	Continued From page 14 assistance to get this fixed, since it was available in other assessments. The licensee's Individual Abuse Prevention Plan policy dated January 1, 2025, noted the plan would include an assessment of the person's risk of abusing other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
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, record review, and interview, 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:	0 775		

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0 775	Continued From page 15 Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated January 20, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 790 SS=D	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, 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 an isolated scope (when one or a	0 790		

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0 790	Continued From page 16 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated January 20, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=E	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, 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	0 800		

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0 800	Continued From page 17 resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated January 20, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
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.	0 810		

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0 810	Continued From page 18 (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, 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 January 20, 2026, for the specific violations	0 810		

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0 810	Continued From page 19 related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a current written service plan was finalized no later than 14 calendar days after the date that services were first provided, for two of three residents (R1, R2),	01640		

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01640	Continued From page 20 and failed to ensure service plans included a signature documenting agreement on the services 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 a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: NO SERVICE PLAN R1 R1 was admitted for assisted living services on December 30, 2024. R1's diagnoses included hypertension (high blood pressure), arthritis, and Parkinsonism (a group of neurological disorders causing slowness, stiffness, tremor, and postural instability). On January 21, 2026, at 7:55 a.m., the surveyor observed unlicensed personnel (ULP)-D administer medications to R1 in her room. R1's Assessment dated December 30, 2025, noted R1 received assistance with bathing, dressing, hygiene, mobility, toileting, and medication administration. R1's record lacked a service plan. On January 21, 2026, at 1:05 p.m., clinical nurse supervisor/assisted living director in residency	01640		

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01640	Continued From page 21 (CNS/ALDIR)-A stated he was not able to locate a service plan for R1. R2 R2 admitted for assisted living services on February 20, 2025. R2's diagnoses included depression and hypertension (high blood pressure). On January 21, 2026, at 7:30 a.m., the surveyor observed ULP-E perform a blood glucose check and medication administration to R2. R2's Assessment dated December 7, 2025, noted R2 received assistance with bathing, dressing, hygiene, mobility, toileting, and medication administration. R2's record lacked a service plan. On January 21, 2026, at 2:10 p.m., CNS/ALDIR-A stated he was unable to locate a service plan for R2. NO SIGNED SERVICE PLAN R3 R3 was admitted for assisted living services on July 14, 2025, and discharged on October 14, 2025. R3's diagnoses included atrial fibrillation (rapid, irregular heartbeat), chronic kidney disease, and sleep apnea. R3's Service Plan dated July 18, 2025, indicated R3 received services including assistance with ambulation, bathing, grooming, and medication administration. The service plan was signed by R3's representative, but lacked a signature by the	01640		

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01640	Continued From page 22 licensee documenting agreement on the services to be provided. On January 22, 2026, at 11:00 a.m., CNS/ALDIR-A stated the service plan should be signed by the licensee. The licensee's Service Plan policy dated January 1, 2025, noted: - within 14 days after services were first provided, the licensee would finalize a written service plan; and - the service plan and any revisions would include a signature or other authentication by the resident/resident's representative and the licensee. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan.	01760		

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01760	Continued From page 23 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to verify accuracy of prescriber orders when transcribing orders for one of three residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included hypertension (high blood pressure), arthritis, and Parkinsonism (a group of neurological disorders causing slowness, stiffness, tremor, and postural instability). On January 21, 2026, at 7:55 a.m., the surveyor observed unlicensed personnel (ULP)-D administer medications to R1 in her room. R1's Assessment dated December 30, 2025, noted R1 received assistance with bathing, dressing, hygiene, mobility, toileting, and medication administration. R1's record lacked a service plan. R1's prescriber orders dated December 31, 2025, included: - quetiapine 25 milligrams (mg) take one tablet by mouth at bedtime.	01760		

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01760	Continued From page 24 R1's Med (Medication) Admin (Administration) Summary for January 1, 2026, included: - quetiapine 25 mg administer 1 1/2 tablets by mouth at bedtime. On January 21, 2026, at 1:05 p.m., clinical nurse supervisor/assisted living director in residency (CNS/ALDIR)-A stated the order had not been transcribed correctly for this order. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01890 SS=D	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 an open date for one of one resident (R2) and failed to ensure medications were maintained bearing the original prescription label with legible information for one of one resident (R2) with insulin. 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	01890		

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01890	Continued From page 25 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 January 20, 2026, at 9:53 a.m., clinical nurse supervisor/assisted living director in residency (CNS/ALDIR)-A stated the licensee provided medication management services to the licensee's residents. On January 21, 2026, at 8:55 a.m., the surveyor observed the medication cart with unlicensed personnel (ULP)-F and noted the following: - R2's Lantus SoloStar insulin (prefilled insulin pen) lacked a date when opened; and - R2's Lantus SoloStar insulin pen lacked a prescription label. On January 21, 2026, at 10:05 a.m., CNS/ALDIR-A stated insulin pens should be labeled when opened and should have the original prescription label. The licensee's Medications - Prescription Drugs & Prohibition policy dated January 1, 2025, noted prior to being set up for immediate or later administration, the prescription drug must bear the original prescription label including the expiration or beyond-use date of a time-dated medication. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25706	A. BUILDING: _____ B. WING _____	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMOND WILLOW ASSISTED LIVING	1401 5TH AVENUE NE LITTLE FALLS, MN 56345

(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
01890	Continued From page 26 days	01890		
02310 SS=D	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 care and services were provided according to acceptable health care and medical, or nursing standards for one of three residents (R1) with an assistive device (consumer bed 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included hypertension (high blood pressure), arthritis, and Parkinsonism (a group of neurological disorders causing slowness, stiffness, tremor, and postural instability). On January 21, 2026, at 7:55 a.m., the surveyor observed unlicensed personnel (ULP)-D	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25706	A. BUILDING: _____ B. WING _____	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMOND WILLOW ASSISTED LIVING	1401 5TH AVENUE NE LITTLE FALLS, MN 56345

(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 27 administer medications to R1 in her room. R1's bed was observed to have a white metal device on both sides of the bed. The device was square with rounded corners, with one horizontal bar through the middle, three vertical bars under the middle horizontal bar, and one U-shaped bar above the middle horizontal bar. R1's record lacked a service plan. R1's Side Rail (bed rail) Use Assessment Form dated January 2, 2025, noted the rails were indicated to promote independence. R1's Assessment dated December 30, 2025, noted R1 received assistance with bathing, dresing, ambulation, bed transfers, and toileting. It also noted R1 had a catheter, moderately impaired decision making, and had a hospital bed with QBars (an assistive device) on both sides of the bed. R1's record lacked an assessment of whether the rail had the effect of being an improper restraint. On January 21, 2026, at 1:05 p.m., clinical nurse supervisor/assisted living director in residency (CNS/ALDIR)-A stated R1's assessment did not indicate whether the rail had the effect of being an improper restraint. The licensee's Side Rails policy dated January 1, 2025, lacked information on assessing whether the rail had the effect of being an improper restraint. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25706	A. BUILDING: _____ B. WING _____	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMOND WILLOW ASSISTED LIVING	1401 5TH AVENUE NE LITTLE FALLS, MN 56345

(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 28 candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails 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 FDA, "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients." The FDA also identified, "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25706	A. BUILDING: _____ B. WING _____	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMOND WILLOW ASSISTED LIVING	1401 5TH AVENUE NE LITTLE FALLS, MN 56345

(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 29 them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

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

DIAMOND WILLOW ASSISTED LIVING
1401 5th Avenue NE
Little Falls, MN 556345
Morisson County
Parcel:

Phone:

License Info

License: HFID 25706

Risk:
License:
Expires on:
CFPM: KAYLEE R SELINSKI
CFPM #: 6447; Exp: 11/1/2028

Inspection Info

Report Number: F1037261017
Inspection Type: Full - Single
Date: 1/20/2026 Time: 11:40:43 AM
Duration: minutes
Announced Inspection: Yes
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

DISCUSSED MENU, HIGH RISK FOODS, EMPLOYEE ILLNESS RECORDING, BARE HAND CONTACT, COOLING, REHEATING, AND DISHWASHING.

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 F1037261017 from 1/20/2026

KAYLEE SELINSKI

Michelle Hovanes,
Public Health Sanitarian 2
320-223-7307
michelle.hovanes@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

DIAMOND WILLOW ASSISTED LIVING
Little Falls
County/Group: Morisson County

Inspection Info

Report Number: F1037261017
Inspection Type: Full
Date: 1/20/2026
Time: 11:40:43 AM

Food Temperature: Product/Item/Unit: PASTA SALAD**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 40 Degrees F.
Comment: STARLITE KITCHEN
Violation Issued?: No

Food Temperature: Product/Item/Unit: MILK JUG**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 40 Degrees F.
Comment: STARLITE DRY STORAGE ROOM
Violation Issued?: No

Food Temperature: Product/Item/Unit: BEEF STROGANOFF**; Temperature Process:** Cooking
Location: Stove at 168 Degrees F.
Comment: STARLITE KITCHEN
Violation Issued?: No

Food Temperature: Product/Item/Unit: MIXED VEGETABLES**; Temperature Process:** Cooking
Location: Stove at 208 Degrees F.
Comment: STARLITE KITCHEN
Violation Issued?: No

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

Food Temperature: Product/Item/Unit: BEEF STROGANOFF**; Temperature Process:** Cooking
Location: Stove at 192 Degrees F.
Comment: LINDBERG KITCHEN
Violation Issued?: No

Food Temperature: Product/Item/Unit: PEAS**; Temperature Process:** Cooking
Location: Stove at 167 Degrees F.
Comment: LINDBERG KITCHEN
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

DIAMOND WILLOW ASSISTED LIVING
Little Falls
County/Group: Morisson County

Inspection Info

Report Number: F1037261017
Inspection Type: Full
Date: 1/20/2026
Time: 11:40:43 AM

Sanitizing Chemical: **Product:** Chlorine**; Sanitizing Process:** Spray Bottle
Location: Kitchen **Equal To** 100 PPM
Comment: STARLITE KITCHEN
Violation Issued?: No

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Dishwashing Area **Equal To** 168 Degrees F.
Comment: STARLITE KITCHEN
Violation Issued?: No

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Dishwashing Area **Equal To** 167 Degrees F.
Comment: LINDBERG KITCHEN
Violation Issued?: No

Minnesota (MDH) Version
EH Manager; RPT: F1037261017

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	0	Date: 1/20/2026
No. of Repeat Risk Factor/Intervention/Violations		Time: 11:40:43 AM
Score (optional)		Dur: min

Establishment:	Address:	City/State:	Zip:	Phone:
DIAMOND WILLOW ASSISTED LIVING	1401 5th Avenue NE	Little Falls, MN	556345	
License/Permit #:	**Permit Holder:**	**Purpose of Inspection:**	**Est. Type:**	**Risk Category:**
HFID 25706		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

	Compliance Status		COS	R
	Time/Temperature Control for Safety			
18	IN	Proper cooking time & temperatures		
19	N/O	Proper reheating procedures for hot holding		
20	N/O	Proper cooling time and temperature		
21	N/A	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	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	N/A	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/A	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) Michele L Thomas

Follow-up: Follow-up Date:

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL25706016-0	**Date:** January 20, 2026
Facility Name: DIAMOND WILLOW ASSISTED LIVING	
Facility Address: 1401 5TH AVENUE NE, LITTLE FALLS, MN 56345	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]

2. Building occupants shall not be required to pass through more than one controlled egress locked door before entering an exit. [Minn. Stat. 144G.45 subd. 2; MSFC 1010.1.9.7]

   Comments: There was a controlled egress locking system installed on all exterior emergency exit doors in the Lindbergh and Staurolite buildings and on the interior doors in the link. To exit the building using the link, occupants had to pass through two controlled egress doors.

3. The means of egress shall be maintained free of obstructions or impediments to full instant use in case of fire or other emergency. [Minn. Stat. 144G.45 subd. 2; MSFC 1031.2]

   Comments: There were marked emergency exit doors in the living/dining rooms of the Lindbergh and Staurolite buildings. Clear continuous egress paths from these doors to the public right of way were not maintained free of snow and ice.

4. Multiplug adapters, such as cube adapters, unfused plug strips or any other device not complying with NFPA 70 shall be prohibited. [Minn. Stat. 144G.45 subd. 2; MSFC 604.4]

   Comments: Multi outlet plug adapters were used to supply power for two storage room refrigeration units. These refrigeration units were not plugged directly into the electrical wall outlets.

5. Extension cords shall not be a substitute for permanent wiring. Minn. Stat. 144G.45 subd. 2; MSFC 604.5]

Comments: To supply power to personal electronics, two extension cords were daisy chained together in occupied resident room eight, and an extension cord was used in occupied resident room seven. Improper use of extension cords creates a fire hazard.

6. In buildings that contain a fuel-burning appliance or fireplace, or attached private garage, carbon monoxide detection shall be installed in dwelling units within ten feet of bedrooms. Carbon monoxide detection can be provided by carbon monoxide alarms installed in dwelling or sleeping units or a carbon monoxide detection system installed in all rooms or spaces that contain fuel-burning appliances. [Minn. Stat. 144G.45 subd. 2; MSFC 915]

   Comments: Carbon monoxide detectors were installed in the mechanical rooms of the Lindbergh and Staurolite buildings. There were gas fireplaces in the living/dining rooms of these buildings and carbon monoxide alarms were not installed within ten feet of all resident bedrooms.

7. Compressed gas containers, cylinders and tanks shall be secured to prevent falling caused by contact, vibration or seismic activity. [Minn. Stat. 144G.45 subd. 2; MSFC 503.5.3]

   Comments: Two oxygen cylinders stored insecurely on the floor in occupied resident room eight. Oxygen cylinders shall be stored in racks or holders to prevent the cylinders from falling over.

8. Building fire alarm systems shall be inspected and tested annually. [Minn. Stat. 144G.45 subd. 2; MSFC 901.6.1]

   Comments: The fire alarm inspection reports dated November 24, 2025, indicated the supervisory tamper switches and initiating waterflow switches were not tested in the past year for the Lindbergh and Staurolite buildings.

9. Fire-extinguishing systems shall be maintained in an operative condition at all times and shall be replaced or repaired where defective. [Minn. Stat. 144G.45 subd. 2; MSFC 901.6]

   Comments: In the link, one fire sprinkler head was improperly pushed up above the ceiling surface. Fire sprinklers shall be installed with escutcheons that seal the gap between the fire sprinkler head and the ceiling.

10. Open junction boxes and open-wiring splices shall be prohibited. Approved covers shall be provided for all switch and electrical outlet boxes. [Minn. Stat. 144G.45 subd. 2; MSFC 604.6]

    Comments: On the exterior of the Lindbergh and Staurolite buildings, the weatherproof covers were missing from several electrical outlets. Weatherproof covers shall be installed to protect the electrical system and the occupants of these buildings.

☒ **TAG IDENTIFICATION: 0790**

SCOPE/ SEVERITY: Level 2; Isolated **TIME PERIOD OF CORRECTION:** Seven (7) days

1. Portable fire extinguishers installed and maintained to MN State Fire Code. [Minn. Stat. 144G.45 subd.2]

   Comments: Cleaning equipment was stored on the wall in front of the portable fire extinguishers in both laundry rooms. Fire extinguishers must be maintained as readily available.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 2; Pattern **TIME PERIOD OF CORRECTION:** Seven (7) days

1. The physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment are in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. [Minn. Stat. 144G.45 subd.2]

   Comments:
   - On the back of the Lindbergh and Staurolite buildings, large ice dams had formed on the eaves and roof. Melting ice had accumulated on the patio and sidewalk under these ice dams, creating a safety risk to the building occupants.
   - The bathroom exhaust fans were not working in resident rooms seven and ten. Bathroom exhaust fans shall be maintained in working order to remove excess moisture.
   - Light bulbs were not working in the bathroom exhaust fan fixtures in resident rooms six and ten.

☒ **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 are readily available at all times within the facility. [Minn. Stat. 144G.45 subd.2]

   Comments: The fire safety and evacuation plans (FSEP) were kept in binders and stored in the employee offices. Clinical nurse supervisor/assisted living director in residency (CNS/ALDIR)-A stated these offices were sometimes kept locked and all employees had keys. The FSEP was not maintained as readily available to all building occupants and emergency responders.

2. 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:
   - Resident sleeping room numbers were not identified on the emergency evacuation floor plans displayed in the common areas of both buildings.
   - The building layout was not accurate on the emergency evacuation floor plans posted inside resident rooms.
   - The double occupancy resident rooms were not identified on the emergency evacuation floor plans. Accurate emergency floor plans with resident room number labels shall be developed to provide efficient communication for exiting in the event of a fire or similar emergency.

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

   Comments:
   - The fire procedures referenced a wanderguard system which was no longer used.
   - The description of the fire alarm system was not accurate, it referenced smoke alarm installations in buildings where smoke detectors were installed.
   - The 9.06 fire policy was from a third party.
   The licensee failed to develop and maintain the fire safety and evacuation plan with site specific employee actions for the facility and building occupants.

4. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include 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. [Minn. Stat. 144G.45 subd.2]

   Comments: The Lindburgh building emergency evacuation report, dated September 30, 2025, included evacuation procedures for eleven residents. The current resident census for the Lindburgh building was thirteen. The fire safety and evacuation plan lacked individualized evacuation procedures for two residents.

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

   Comments: The surveyor requested records for employee fire safety and evacuation plan (FSEP) training completed in the past twelve months from clinical nurse supervisor/assisted living director in residency (CNS/ALDIR)-A. These FSEP training records were not provided.

6. Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. [Minn. Stat. 144G.45 subd.2]

   Comments: The surveyor requested records for resident fire safety and evacuation training completed in the past twelve months from clinical nurse supervisor/assisted living director in residency (CNS/ALDIR)-A. A training record, dated December 11, 2025, for one resident was provided on fire safety and evacuation. No additional records were provided to support fire safety and evacuation training had been offered to any of the other residents in the past year.

7. Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. [Minn. Stat. 144G.45 subd.2]

   Comments: The surveyor requested records for employee evacuation drills completed in the past twelve months from clinical nurse supervisor/assisted living director in residency (CNS/ALDIR)-A. Four fire evacuation drills and one tabletop fire drill were recorded between August 2025 and January 2026. No additional evacuation drill records were provided. The licensee failed to conduct evacuation drills at the required frequency.