Electronically Delivered

June 15, 2026

Licensee
Home Front First
224 North 19th Street
Montevideo, MN 56265

RE: Project Number(s) SL21051016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 14, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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

pursuant to this survey:

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

Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21051	A. BUILDING: _____ B. WING _____	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME FRONT FIRST	224 NORTH 19TH STREET MONTEVIDEO, MN 56265

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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: SL21051016-0 On May 12, 2026, through May 14, 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 20 residents; 20 receiving services under the Assisted Living Facility license. 1290: An immediate correction order was issued on May 12, 2026, at a level 3/Widespread (I). The licensee took immediate action; however, the scope and level remains at I.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated May 12, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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0 480	Continued From page 3 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program that complies with accepted health care, medical and nursing standards for infection control for one of three unlicensed personnel (ULP-H). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	0 510		

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0 510	Continued From page 4 On May 13, 2026, beginning at 7:25 a.m., the surveyor continually observed ULP-H administering medications. The surveyor observed the following: - 7:25 a.m. ULP-H retrieved R1's insulin pen from the medication cart, went to R1's room, put on gloves, administered the insulin, removed gloves, and returned to the medication cart. ULP-H did not wash hands or use hand sanitizer; - 7:32 a.m. ULP-H set up oral medication for R4, went to R4's room, administered the medication, and returned to the medications cart. ULP-H used hand sanitizer; - 7:35 a.m. ULP-H set up R5's oral medications for administration, went to R5's room, administered the medications, and returned to the medication cart. ULP-H did not wash hands or use hand sanitizer; - approximately 11:40 a.m. ULP-H went to R1's room to remind R1 to go to breakfast. ULP-H made R1's bed. ULP-H did not wash hands or use hand sanitizer; - immediately following, ULP-H walked across the hall and made R5's bed, placed clean laundry from a hamper onto the bed, and put it away in drawers. ULP-H then took some dirty laundry, put it in the hamper and brought it to the laundry room. ULP-H did not wash hands or use hand sanitizer; - at 11:50 a.m. ULP-H administered oral medications to R2, returned to the laundry room, started R5's laundry and washed their hands. On May 13, 2026, at 12:30 p.m., clinical nurse supervisor (CNS)-C stated staff should wash hands or use hand sanitizer between resident medications passes, or other cares/services. The licensee's 8.17 Hand Washing policy dated	0 510		

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0 510	Continued From page 5 May 27, 2025, included the following: Proper hand washing techniques should be used to protect the spread of infection. Hand washing shall be completed: Before, during, and after preparing food Before eating food Before and after caring for someone who is sick Before and after treating a cut or wound After using the toilet After changing briefs or cleaning up after someone who has used the toilet After blowing your nose, coughing, or sneezing After touching an animal or animal waste After handling pet food or pet treats After touching garbage Before and after administering medications to a resident Before putting on gloves After removing gloves No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 650 SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training	0 650		

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0 650	Continued From page 6 and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records included all required content for one of two employees (unlicensed personnel (ULP)-H). 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: ULP-H was hired on October 6, 2017, and began providing assisted living services for the facility on August 1, 2021. On May 13, 2026, at 7:25 a.m., the surveyor observed ULP-H administering medications to the	0 650		

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0 650	Continued From page 7 facility's residents. ULP-H's employee file lacked evidence of a Baseline TB (tuberculosis) Screening Tool for Health Care Workers and evidence of TB testing. On May 14, 2026, at 10:41 a.m., the surveyor received an email from executive director (ED)-B, indicating the licensee did not have a copy of the TB screening or testing in ULP-H's employee file. At 11:00 a.m. via email, ED-B further noted the TB testing was done. ULP-H told ED-B that the facility nurse at that time had given her the two step TB skin testing (TST). On May 14, 2026, at 4:00 p.m., ED-B stated ULP-H told ED-B she remembered receiving the TST and returning for the second TST. ED-B stated it must not have been scanned into her file since it was not there. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota	0 775		

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0 775	Continued From page 8 Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated May 13 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of	01060		

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01060	Continued From page 9 Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with all the required content to the resident, legal representative, designated representative, and ombudsman for an emergency relocation for one of one resident (R7). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01060		

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01060	Continued From page 10 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: R7's Resident Notes dated February 24, 2026, indicated R7 was transferred to the emergency room and admitted to the hospital with a diagnosis of pneumonia. R7's Discharge/Transfer Summary dated April 27, 2026, indicated R7 was discharged to a long term care facility on April 23, 2026. R7's record lacked evidence of a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal.	01060		

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01060	Continued From page 11 The record lacked evidence the above written notice had been provided as soon as practicable to the the resident, legal representative, designated representative, and case manager. There was no evidence the ombudsman had been notified when he was in the hospital and had not returned to the facility within four days. On April 14, 2026, at 12:20 p.m., executive director (ED)-B sent an email to the surveyor noting the nurses did not have an emergency transfer notice for R7. On April 14, 2026, at 4:00 p.m., ED-B stated an emergency transfer notice with the required content and the required notifications should have been completed when R7 transferred to the hospital. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
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	01290		

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01290	Continued From page 12 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 submitted through the Minnesota Department of Human Services (DHS) NETStudy 2.0 and received in affiliation with the assisted living license for one of one employee (unlicensed personnel (ULP)-F). This resulted in an immediate correction order on May 12, 2026. In addition, the licensee failed to ensure one of one employees (ULP-G) had a background study affiliation with this provider's Health Facility Identification (HFID) number 21051. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: SUBMITTED BACKGROUND STUDY ULP-F was hired on July 12, 2024, and provided unsupervised direct care to the licensee's residents. The licensee's NETStudy 2.0 roster dated May 12, 2026, did not include ULP-F. The licensee's NETStudy 2.0 search identified	01290		

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01290	Continued From page 13 ULP-F was separated on May 4, 2026. The licensee's staff schedule indicated ULP-F worked on May 10, 2026, and May 11, 2026, after she was separated. On May 12, 2026, at 12:50 p.m., executive director (ED)-B stated she could not find ULP-F on the active NETStudy roster. At 12:58 p.m., ED-B further stated she found a background study clearance letter dated July 12, 2024. ED-B stated although she had a background study she had been separated in NETStudy because her legal name was not the same as her preferred name so they did not recognize ULP-F's name. AFFILIATION OF BACKGROUND STUDY ULP-G ULP-G was hired on June 10, 2020, and provided unsupervised direct care to the licensee's residents. The licensee's NETStudy 2.0 roster dated May 12, 2026, did not include ULP-G. NETStudy 2.0 listed ULP-G separated from HFID 21051, on August 10, 2022. It also included ULP-G had an active background study clearance for HFID 23849, another licensee owned by the same owner. On May 12, 2026, at 12:50 p.m., ED-B stated ULP-G was not listed on the NETStudy roster and she only had access to the roster for HFID 21051. The licensee's 3.38 Background Checks policy dated August 1, 2021, included the licensee would conduct a Minnesota DHS Background Study on all team members and volunteers of the licensee. No team member may have	01290		

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01290	Continued From page 14 independent direct contact with any tenants or clients until acceptable result of the background study had been received. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate The licensee took immidiate action to mitigate risk; however, the scope and level remains at I.	01290		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and	01620		

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01620	Continued From page 15 (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive assessment including all required information in the Uniform Assessment Tool for one of one resident (R1) every 90 days as required. 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	01620		

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01620	Continued From page 16 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On May 13, 2026, at 7:25 a.m., the surveyor observed unlicensed personnel (ULP)-H administering medications to R1. R1's unsigned service plan dated April 7, 2026, indicated R1's services included blood glucose monitoring and medication administration. R1's record included the following assessments: - Clinical Update Assessment dated October 12, 2025; and - Clinical Update Assessment dated January 12, 2026. There was 92 days between the above assessments, thus exceeding 90 calendar days. On May 13, 2026, at 12:30 p.m., clinical nurse supervisor (CNS)-C stated assessments should have been completed every 90 days or less. The licensee's 11.01 Assessments, Reviews & Monitoring policy dated September 10, 2025, indicated ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		

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01760	Continued From page 17	01760		
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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered as prescribed for one of two 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: On May 13, 2026, at 8:20 a.m., the surveyor observed unlicensed personnel (ULP)-H	01760		

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01760	Continued From page 18 administering medications to R1. ULP-H removed the polyethylene glycol (laxative) from the cart, opened the bottle, poured into the cap approximately halfway up the white insert in the cap, poured it into a glass, filled the glass with water, mixed the solution and administered it to R1. ULP-H stated the screw thread on the cap (which was approximately halfway to the top of the white rim) was the measuring line. On May 13, 2026, at 8:20 a.m., the surveyor observed R1's polyethylene glycol pharmacy label indicated 1 capful in liquid once daily. R1's physician orders dated March 27, 2026, included Miralax (polyethylene glycol) 17 grams mix in 8 ounces of water once daily in the morning. R1's medication administration record (MAR) dated May 2026, included Miralax 17 grams mix in 8 ounces of water once daily in the morning. Polyethylene glycol's undated label read "the bottle cap is a measuring cup designed to contain 17 grams of powder when filled to the top rim". On May 13, 2026, at 12:30 p.m., clinical nurse supervisor (CNS)-C stated the top of the white insert equaled the 17 grams, and staff should have filled it to top of the white rim. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01880 SS=E	144G.71 Subd. 19 Storage of medications	01880		

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01880	Continued From page 19 An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure refrigerated medications were stored at the appropriate temperature in the facility's one medication refrigerator. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On May 13, 2026, at 10:15 a.m., the surveyor observed the medication refrigerator with unlicensed personnel (ULP)-E. The medication refrigerator temperature at the time of observation was 48 degrees Fahrenheit. ULP-E stated the temperature of the refrigerator was set to "max." The following medications were inside the refrigerator: R1 - Lantus insulin pens and Novolog insulin pens R3 - Lantus insulin pens and Aspart insulin pens The Fridge Temperature Log (Food) dated May	01880		

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01880	Continued From page 20 2026, had "Med Fridge" handwritten on it and it included the following: - "Fridge: Must be between 33-40 degrees." - "Notify Manager if outside these temperature ranges." - temperature recordings each shift included; - May 1 - night documented 34 degrees and a.m. documented 34 degrees - May 2 - night documented 32 degrees - May 3 - a.m. documented 50 degrees - May 4 - night documented 25 degrees and p.m. documented 35 degrees - May 6 - p.m. documented 49 degrees - May 7 - a.m. documented 50 degrees and p.m. documented 30 degrees - May 8 - night documented 32 degrees, a.m. documented 32 degrees and p.m. documented 35 degrees - May 10 - p.m. documented 32 degrees - May 11 - night documented 23 degrees, a.m. documented 35 degrees and p.m. documented 35 degrees On May 13, 2026, at 12:30 a.m., clinical nurse supervisor (CNS)-C stated the medication temperature log was "all over the place" and the document did not include the correct temperature for medication storage. CNS-C further stated medications should be stored per manufacturer instructions. Lantus prescribing information dated November 2018, identified unopened Lantus pens were to be stored at temperatures between 36 and 46 degrees Fahrenheit. Novolog (aspart) prescribing information dated December 2012, identified unopened Novolog was to be stored in the refrigerator with temperatures between 36 and 46 degrees	01880		

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01880	Continued From page 21 Fahrenheit. The licensee's 12.17 Medication Storage policy dated August 11, 2025, included "Medications will be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen)." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by:	01910		

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01910	Continued From page 22 Based on interview and record review, the licensee failed to to include all required information on the medication disposition for one of one discharged resident (R7). 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: R7's progress notes included the following: - On February 24, 2026, at 11:32 a.m. R7 complained of not feeling well and was transported to the emergency room. - On February 25, 2026, at 10:21 a.m. "Residents [sp] Linzess (for irritable bowel disease) bottle and tiotropium-olodaterol inhaler (used for chronic lung disease) was brought to [hospital name] for use." The information did not include the prescription number, strength, or the quantity, as required. - On March 9, 2026, R7 was transferred to a long term care facility. - April 24, 2026, the facility was notified R7 was discharging to the long term care facility. R7's Current Medications at Discharge dated May 1, 2026, included the following medications which did not include prescription numbers as required: - clopidogrel 75 mg (chronic heart failure); - duloxetine 60 mg (depression); - levocarnitine 500 mg (kidney disease); - clindamycin 300 mg (prophylactic antibiotic);	01910		

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01910	Continued From page 23 - Melatonin 3 mg (sleep); - Metamucil packets (laxative); - multivitamin (dietary supplement); - omeprazole (gastroesophageal reflux); - Preservision (dietary supplement); - Senna-S (stool softener); - spironolactone 25 mg (chronic heart failure); - ciprofloxacin (antibiotic); - Wellbutrin 300 mg (anxiety); - acetaminophen 500 mg (pain); - magnesium hydroxide solution (constipation); - Nystatin powder (reddened skin); - polyethylene glycol (laxative); - simethicone 125 mg (flatulence); and - Trazadone 50 mg (sleep). On May 14, 2027, at 4:00 p.m., executive director (ED)-B stated R7's medication disposition should have included all the required content. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
02320 SS=E	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record	02320		

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02320	Continued From page 24 review, the licensee failed to ensure three of four unlicensed personnel (ULP-H, ULP-E, ULP-D) administered medications according to policy and accepted standards of practice. 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: ULP-H Insulin: On May 13, 2026, at 7:25 a.m., the surveyor observed ULP-H administering Novolog insulin to R1. ULP-H removed the insulin pen from the medication cart, went to R1's room, removed the cap and placed the pen needle onto the pen. ULP-H did not clean the rubber stopper prior to placing the needle. ULP-H then primed the insulin pen with 2 units, dialed the insulin pen to the correct dose, injected the insulin into R1, and immediately removed the needle from the skin. ULP-H did not clean the skin injection site prior to administration and did not hold the needle in the skin for six seconds as per manufacturer recommendations. On May 13, 2026, at 10:45 a.m., the surveyor observed ULP-H administering Novolog insulin to R3. ULP-H removed the insulin pen from the medication cart, went to R3's room, removed the cap and placed the pen needle onto the pen.	02320		

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02320	Continued From page 25 ULP-H did not clean the rubber stopper prior to placing the needle. ULP-H then primed the insulin pen with 2 units, dialed the insulin pen to the correct dose, cleaned the skin, injected the insulin, and immediately removed the needle from the skin. ULP-H did not hold the needle in the skin for six seconds as per manufacturer recommendations. On May 13, 2026, at 12:30 p.m., CNS-C stated when administering insulin, staff should clean the rubber stopper prior to placing on the needle, staff should clean the skin prior to the injection, and should hold the needle in the skin for 10 seconds after injection. Novolog prescribing information dated February 2015, included the following: - remove the pen cap and clean the rubber stopper with an alcohol swab; - Keep the needle in the skin for at least six seconds after injecting and keep the push button pressed all the way until the needle is removed from the skin. Eye drops: On May 13, 2026, at 8:20 a.m., the surveyor observed ULP-H administering eye drops to R1. ULP-H placed a drop of dorzolamide eye drops in both eyes. Right after the eye drop administration, ULP-H administered a drop of prednisolone into R1's right eye, and a drop of brimonidine into R1's left eye. ULP-H did not wait at least five minutes between eye drops. Dorzolamide prescribing information dated December 2020, included "if more than one topical ophthalmic drug is being used, the drugs should be administered at least five minutes apart."	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21051	A. BUILDING: _____ B. WING _____	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME FRONT FIRST	224 NORTH 19TH STREET MONTEVIDEO, MN 56265

(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
02320	Continued From page 26 Alphagan (brimonidine) prescribing information dated March 2016, included "If more than one topical ophthalmic product is to be used, the different products should be instilled at least 5 minutes apart." On May 13, 2026, at 12:30 p.m., CNS-C stated staff are to wait at least five minutes between different eye drops. The licensee's Eye Drops & Ointment policy dated August 13, 2025, included: - If more than one kind of eye drop is being used, wait at least 5 minutes before using each type. ULP-E On May 13, 2026, at 7:59 a.m., the surveyor observed ULP-E administering diclofenac gel to R6. ULP-E applied gloves, squeezed some diclofenac gel directly onto her gloved hand and rubbed it onto R6's left knee. ULP-E then squeezed more gel directly onto her glove and rubbed it onto R6's right knee. On May 13, 2026, at 12:30 p.m., the surveyor observed R6's diclofenac gel box with clinical nurse supervisor (CNS)-C and noted the manufacturer measuring strip was still attached to the instructions for use and the tube of diclofenac was approximately half empty. CNS-C stated staff should have used the manufacturer's measuring strip to measure the diclofenac gel. R6's MAR dated May 2026, included diclofenac sodium 1% gel, apply 4 grams topically to both hips and knees two times a day. R6's physician orders dated November 13, 2025, included diclofenac sodium 1% gel, apply 4	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21051	A. BUILDING: _____ B. WING _____	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02320	Continued From page 27 grams topically to both hips and knees two times a day. The licensee's 12.75 Topical Application of Ointment & Cream policy dated August 14, 2025, included: - Topical ointment and cream medications must be applied according to the prescriber orders; - Medications always need to be administered according to the "6 Rights" - Right person - Right medication - Right time - Right route (i.e., by mouth, eye drop, to the skin) - Right dose (i.e., how many milligrams, drops) - Right chart/record to document" Diclofenac (Voltaren) prescribing information dated July 2009, included the following: - To measure the right amount of Voltaren® Gel, place the dosing card on a flat surface so that you can read the print. - Squeeze Voltaren® Gel onto the dosing card evenly up to the 4 gram line, making sure the gel covers the entire 4 gram area of the dosing card, as shown in the picture below. Put the cap back on the tube of Voltaren® Gel. ULP-D On May 12, 2026, at 10:44 a.m., the surveyor observed ULP-D administering insulin to R3. ULP-D removed the insulin pen from the cart and went down the hall and into R3's room. ULP-D checked R3's blood sugar and stated R3's blood sugar was 199; therefore, R3 would receive 2 units of insulin. ULP-D dialed the insulin pen to 2 and administered the dose. ULP-D did not check	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21051	A. BUILDING: _____ B. WING _____	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02320	Continued From page 28 R3's MAR prior to administering the dose of insulin. When asked, ULP-D stated the sliding scale was in R3's MAR. ULP-D walked out of the room and to the medication cart, opened the computer, went to R3's MAR and showed the surveyor the sliding scale. On May 13, 2026, at 12:30 p.m., CNS-C stated staff should have checked R3's blood sugar, returned to the computer and checked what dose should be administered and returned to the room to administer that dose. CNS-C further stated staff should always be checking the MAR prior to administration of any medications. The licensee's Insulin policy dated August 13, 2025, included: - insulin would be administered according to the prescriber's orders; and - Compare the information of the MAR with the label on the medication container. The following information should be in all the places: - Resident name - Name of the medication - The strength and dosage of the medication - The route - The time that the medication is to be given - Any special instructions No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

Fergus Falls District Office
Minnesota Department of Health
2312 College Way
Fergus Falls , MN 56537
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Home Front First
224 NORTH 19TH STREET
Montevideo, MN 56265
Chippewa
Parcel:

Phone:

License Info

License: HFID 21051

Risk:
License:
Expires on:
CFPM: Carley Haukos
CFPM #: 65349; Exp: 3/4/2029

Inspection Info

Report Number: F7935261049
Inspection Type: Full - Single
Date: 5/12/2026 Time: 11:27:39 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 1
Total Priority 2 Orders: 0
Total Priority 3 Orders: 1
Delivery:

! **New Order: 3-500B Microbial Control: hot and cold holding**
3-501.16A2 *Priority Level: Priority 1 CFP#: 22*
MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.
COMMENT: 3 door upright cooler was 42-43 degrees.
Comply By: 5/12/2026 Originally Issued On: 5/12/2026

New Order: 4-500 Equipment Maintenance and Operation
4-501.11AB *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.
COMMENT: Repair 3 door cooler to maintain a temp of 41 or below. Service ticket has been submitted.
Comply By: 5/12/2026 Originally Issued On: 5/12/2026

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 Fergus Falls District Office inspection report number F7935261049 from 5/12/2026

Rebecca Tonneson

Establishment Representative

Rebecca Tonneson, RS
Public Health Sanitarian Supervisor
218-332-5142
rebecca.tonneson@state.mn.us

Fergus Falls District Office
Minnesota Department of Health
2312 College Way
Fergus Falls , MN 56537

Temperature Observations/Recordings

Establishment Info

Home Front First
Montevideo
County/Group: Chippewa

Inspection Info

Report Number: F7935261049
Inspection Type: Full
Date: 5/12/2026
Time: 11:27:39 AM

Equipment Temperature: Product/Item/Unit: 3 door upright cooler**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 43 Degrees F.
Comment:
Violation Issued?: Yes

Food Temperature: Product/Item/Unit: Rice**; Temperature Process:** Hot-Holding
Location: Warmer at 196 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Taco Meat**; Temperature Process:** Hot-Holding
Location: Warmer at 162 Degrees F.
Comment:
Violation Issued?: No

Fergus Falls District Office
Minnesota Department of Health
2312 College Way
Fergus Falls , MN 56537

Sanitizer Observations/Recordings

Establishment Info

Home Front First
Montevideo
County/Group: Chippewa

Inspection Info

Report Number: F7935261049
Inspection Type: Full
Date: 5/12/2026
Time: 11:27:39 AM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Dishwashing Area **Equal To** 160 Degrees F.
Comment:
Violation Issued?: No

Sanitizing Chemical: **Product:** Chlorine**; Sanitizing Process:** Wiping Cloth Bucket
Location: Dishwashing Area **Equal To** 50 PPM
Comment:
Violation Issued?: No

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL21051016-0	**Date:** 5/13/2026
Facility Name: Home Front First	
Facility Address: 224 North 19th St, Montevideo, Mn 56265	

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

   Comments: At the time of survey, the fire alarm panel had an inspection tag dated 2022, and recent documentation could not be provided.

3. Storage shall be maintained 2 feet (610 mm) or more below the ceiling in nonsprinklered areas of buildings or a minimum of 18 inches (457 mm) below sprinkler head deflectors in sprinklered areas of buildings. [Minn. Stat. 144G.45 subd. 2; MSFC 315.3.1]

   Comments: At the time of survey, in the maintenance shop various wood trim boards and pvc pipes were stored on the sprinkler pipes.

4. Exits and exit access doors shall be marked by an approved exit sign readily visible from any direction of egress travel. The path of egress travel to exits and within exits shall be marked by readily visible exit signs to clearly indicate the direction of egress travel in cases where the exit or the path of egress travel is not immediately visible to the occupants. [Minn. Stat. 144G.45 subd. 2; MSFC 1013.1]

   Comments: At the time of survey, multiple exit signs did not indicate the direction of egress travel.