Electronically Delivered

January 15, 2026

Licensee
Hillcrest Senior Living
311 Broadway Avenue Northeast
Red Lake Falls, MN 56750

RE: Project Number(s) SL31767016

Dear Licensee:

On December 29, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on October 29, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

CLN

Electronically Delivered

November 20, 2025

Licensee
Hillcrest Senior Living
311 Broadway Avenue Northeast
Red Lake Falls, MN 56750

RE: Project Number(s) SL31767016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 29, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Jessie Chenze

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

KKM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31767	A. BUILDING: _____ B. WING _____	10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST SENIOR LIVING	311 BROADWAY AVENUE NE RED LAKE FALLS, MN 56750

(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: SL31767016-0 On October 27, 2025, through October 29, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 23 residents; 23 receiving services under the Assisted Living Facility with Dementia Care license. An immediate correction order was identified on October 28, 2025, issued for SL31767016-0, tag identification 1290. The licensee took action on October 28, 2025, to mitigate the risk; however, the scope and level remains at level 3/Widespread (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,	0 480		

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0 480	Continued From page 2 existing floor, wall, and ceiling finishes are 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 October 28, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24	0 480		

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0 480	Continued From page 3 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services (a) All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not require any resident to include and pay for meals as a part of their assisted living contract. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety)	0 485		

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0 485	Continued From page 4 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 October 27, 2025, at 10:37 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated the licensee provided residents three meals per day and the licensee offered meal plans to residents. On page five of the licensee's undated Assisted Living Contract section three Housing: number one Housing Related Services Included in the Monthly Rent: g. Availability of three (3) nutritious meals and two (2) snacks per day. The licensee's undated Meal/Food Plan Addendum indicated please select one of the following Meal/Food [sic] pan options: -Three (3) meals and two (2) snacks each day; or -No meal plan through (licensee name). Resident assisted living contracts and meal/food plan addendums lacked an option for residents to opt out of payment for one or two meals residents would not want. On October 29, 2025, at 10:08 a.m., LALD/RN-A stated the licensee meal plan addendum, offered to all residents, was to opt in to receive all meals or opt out of all meals. LALD/RN-A further stated the licensee was aware residents could opt out of meals, however, was not aware the meal plan could not be a one size fits all meal charge. The Minnesota Department of Health Assisted	0 485		

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0 485	Continued From page 5 Living Resources and Frequently Asked Questions (FAQs) website, last updated October 13, 2025, indicated the provider cannot have a blanket "one size fits all" meal charge. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule.	0 680		

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0 680	Continued From page 6 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents, staff, and visitors of the facility. 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 October 27, 2025, at 10:32 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated the licensee was familiar with current minimum assisted living requirements. The licensee's EPP, dated July 2021, lacked the following required content: -yearly review of the EPP; -quarterly review of the missing resident policy; and - a communication plan that included names and contact information for current staff. On October 28, 2025, at 2:21 p.m., LALD/RN-A stated the licensee had not updated or reviewed the EPP, including the missing resident policy, since leadership and administration had changed, and the most recent review	0 680		

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0 680	Continued From page 7 documented was July 2021. LALD/RN-A further stated the EPP lacked current contact staff names and contact information for the licensed assisted living director (LALD), director of maintenance (DM), and clinical nurse supervisor (CNS). The licensee's Missing Resident policy dated September 20, 2023, did not address how often the Missing Resident policy would be reviewed. The licensee Disaster Planning and EPP policy dated May 25, 2023, indicated (licensee name) will have in place a written plan of action to facilitate the management of clients' (residents') care and services in response to a natural disaster or other emergencies that may disrupt their ability to provide care and/or services. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0110, Subp. 4, effective October 2022, the assisted living director and CNS must review the missing person plan at least quarterly and document any changes to the plan. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0100, sections A and B, effective October 2022, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference.	0 680		

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0 680	Continued From page 8 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the requirements of the Minnesota State Fire Code. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: On a facility tour on October 28, 2025, from 12:35 p.m. to 1:45 p.m., with director of maintenance (DM)-D, the surveyor made the following observations of non-compliance with the requirements of the Minnesota State Fire Code (MSFC) in Minnesota Rules Chapter 7511: EXIT DOOR LOCKING ARRANGEMENTS	0 775		

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0 775	Continued From page 9 There was a controlled egress locking system installed on the emergency exit doors in the north building leading to the exterior exit path. The controlled egress door locking system was not provided with a device capable of deactivating the delayed egress door hardware to the unlocked position from the nurse station or other approved location for occupants to exit in the event of an emergency. The controlled egress locking system is required to be provided with a switch or device located at the nurse station or other approved location to deactivate the delayed egress locked exit doors for building occupants to exit in the event of an emergency. The procedures required to operate and unlock the controlled egress locking system for occupants to exit in the event of an emergency are required to be included in the fire safety and evacuation plan employee procedures. These procedures are required in accordance with MSFC in Minnesota Rules Chapter 7511. FIRE RATED DOORS Surveyor observed the fire rated door between the north wing and memory care unit was propped open with a door wedge. Fire resistant rated doors are required to automatically close and latch to prevent the spread of flame and smoke in the event of a fire or similar emergency in accordance with MNSFC Section 1105. These deficient conditions were visually verified by DM-D accompanying on the tour. DM-D stated that staff likes to prop them open as the residents have a hard time opening them when they have	0 775		

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0 775	Continued From page 10 to go to and from the dining room. These doors do not have a magnetic holder to keep them open. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in 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	0 810		

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HILLCREST SENIOR LIVING	311 BROADWAY AVENUE NE RED LAKE FALLS, MN 56750

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0 810	Continued From page 11 activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On October 28, 2025, at 1:50 p.m. director of maintenance (DM)-D provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. The FSEP that was provided had the RACE acronym and was very basic. It did not have the specific actions that staff and residents would take in the event of a fire or similar emergency. DM-D stated he understood the requirements of this plan would update it with more details.	0 810		

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0 810	Continued From page 12 TRAINING: The licensee failed to provide evacuation training to staff and residents as required. DM-D stated that he understood the requirements for training the employees and residents. DRILLS: The licensee failed to conduct evacuation drills for employees as required. DM-D stated that he understood the requirements for employees conducting evacuation drills twice per year per shift with at least one evacuation drill every other month. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01060 SS=F	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 13 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 observation, interview, and record review, the licensee failed to provide written notice with required content to the resident, legal representative, and designated representative, and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) when the resident did not return from the emergency relocation within four days for one of	01060		

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01060	Continued From page 14 one 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 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 October 27, 2025, at 10:32 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated the licensee was familiar with current minimum assisted living requirements. R7's diagnoses included obstructive sleep apnea, arthritis, and depression. R7's Service Plan- Waiver- MN (Minnesota) dated February 10, 2025, indicated R7 received medication administration, TEDS (compression stockings used to prevent blood clots and decrease swelling in the legs), BiPap (non-invasive ventilation therapy to help with breathing problems), and assistance with bathing, grooming, dressing, and transfers. On October 28, 2025, at 7:25 a.m., the surveyor observed unlicensed personnel (ULP)-G put on R7's TEDS. R7's Assessments dated August 3, 2025, and October 19, 2025, respectively, indicated R7 was hospitalized from May 1, 2025, through May 5,	01060		

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01060	Continued From page 15 2025, due to pneumonia. R7's record lacked a written notice that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the OOLTC; - 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 - 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. In addition, R7's record lacked notification to the OOLTC that the resident had been relocated and had not returned to the facility within four days. On October 29, 2025, at 10:10 a.m., LALD/RN-A stated the licensee was not aware of the emergency relocation written notice requirement, however, LALD/RN-A stated the licensee notified the resident's representative and case worker via telephone to inform them of R7's hospitalization. The licensee's Emergency Relocation policy dated May 16, 2023, indicated in the event of an emergency relocation, (licensee name) will provide a written notice to the resident, legal representative, designated representative, resident's case manager, if applicable, and the OOLTC (if the resident has not returned to the facility within four days) that contains, at a	01060		

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01060	Continued From page 16 minimum: -The reason for the relocation; -The name and contact information for the location to which the resident has been relocated and any new service provider; -Contact information for the OOLTC; -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 -A statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal. 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 this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits.	01290		

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01290	Continued From page 17 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure current employee records contained all the required content to include a current background study clearance letter for one of 10 employees (unlicensed personnel (ULP)-I). This had the potential to affect all residents living within the facility. 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: This resulted in an immediate correction order on October 28, 2025. During the entrance conference on October 27, 2025, at 10:44 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated the licensee was aware of required contents in an employee record. ULP-I was hired on May 7, 2018, and had begun to provide direct care services to residents effective August 1, 2021. The licensee's weekly schedule dated October 27, 2025, through November 2, 2025, indicated ULP-I was scheduled to work three shifts. ULP-I's payroll data dated September 21, 2025,	01290		

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01290	Continued From page 18 through October 6, 2025, indicated ULP-I had worked 168.25 hours. ULP-I's employee record contained a cleared Minnesota (MN) Department of Human Services (DHS) Background Study dated September 27, 2021. ULP-I's employee record lacked a current cleared background study listed on the licensee's NETSTudy 2.0 Roster. On October 28, 2025, from 2:27 p.m., through 2:40 p.m., the surveyor reviewed the licensee's NETSTudy 2.0 Roster with licensed assisted living director in residency (LALDIR)-J, clinical nurse supervisor (CNS)-B, and LALD/RN-A. LALDIR-J stated LALDIR-J was responsible for completion of employee background checks upon hire and background studies were required for all employees. LALDIR-J further stated ULP-I was a current employee of the licensee, ULP-I worked unsupervised, and ULP-I was not listed on the licensee's NETStudy 2.0 Roster. LALDIR-J searched the NETStudy 2.0 website with ULP-I's last name, social security number, and date of birth. LALDIR-J stated the search results indicated the entity was no longer affiliated with this person (ULP-I) and can no longer review this file. CNS-B stated the licensee would not be notified if ULP-I's background study became ineligible as the licensee is unable to access ULP-I's information on NETStudy 2.0. The licensee's Employment Background Checks policy last reviewed May 30, 2023, indicated (licensee name) will conduct a MN DHS Background Study on all employees of the facility. No employee may have independent	01290		

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01290	Continued From page 19 direct contact with any resident until acceptable results of the background study have been received. Continuous Direct Supervision defined in NETStudy 2.0 System User Manual Updated July 7, 2023, page 7: Continuous, Direct Supervision - An individual is within sight or hearing of the program's supervising individual to the extent that the program's supervising individual is capable at all times of intervening to protect the health and safety of the persons served by the program. Direct Contact Services - Providing face-to-face care, training, supervision, counseling, consultation, or medication assistance to persons served by the entity. Supervision defined in, NETStudy 2.0 System User Manual Updated July 7, 2023, page 53: Supervision Status Study subjects must be under continuous, direct supervision until the study subject is determined eligible of until the entity is notified by DHS that the study subject may provide unsupervised services while the background study is being completed. The supervision status is shown in the "Supervision Required" column for convenience. However, programs are instructed to rely on background study notices for supervision status and other background study determination information. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290		
01550 SS=D	144G.64 (a) (4) Training in Dementia, Mental Illness, and De- (4) staff who do not provide direct care, including	01550		

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01550	Continued From page 20 maintenance, housekeeping, and food service staff, must have at least four hours of initial training on topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date, and must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of two employees (director of maintenance (DM)-D) received the required amount of mental illness and de-escalation in the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on October 27, 2025, at 10:44 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated the licensee was aware of required contents in an	01550		

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01550	Continued From page 21 employee record. DM-D was hired on December 30, 2024, to provide maintenance around the assisted living with dementia care facility. On October 28, 2025, from 12:35 p.m. through 1:45 p.m., DM-D toured the facility with the Minnesota Department of Health engineer surveyor. DM-D's employee record lacked two hours of initial training on mental illness and de-escalation. On October 28, 2025, at 2:13 p.m., LALD/RN-A stated DM-D was assigned two hours of mental illness and de-escalation training on the licensee's online training platform, however, DM-D had not completed the trainings as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01550		
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.	01640		

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01640	Continued From page 22 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 the service plan was revised to reflect the current services provided for one of four residents (R3). In addition, the licensee failed to ensure the service plan included a resident or resident representative's signature and a licensee signature or other authentication by the licensee to document agreement on the services to be provided for one of four residents (R8). 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).	01640		

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01640	Continued From page 23 The findings include: During the entrance conference on October 27, 2025, at 10:32 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated the licensee was familiar with current minimum assisted living requirements. SERVICE PLAN REVISION R3's diagnoses included major neurocognitive disorder, left hemiplegia (weakness on the left side of the body), anxiety, and depression. On October 28, 2025, at 6:38 a.m., the surveyor observed unlicensed personnel (ULP)-F administer R3's scheduled morning medication. During the observation, the surveyor observed an ankle foot orthosis (AFO) brace on R3's floor. ULP-F stated R3 wore the AFO brace every day. R3's prescriber orders dated October 17, 2024, included an order for a left AFO brace. R3's service plan dated June 5, 2024, lacked application and removal of the AFO brace daily. On October 29, 2025, at 10:22 a.m., LALD/RN-A stated R3's service plan lacked staff assistance to apply and remove R3's left AFO brace. LALD/RN-A further stated R3's left AFO brace was listed as a service in R3's electronic medical record instead of a treatment. SERVICE PLAN AUTHENTICATION R8's diagnoses included right side hemiparesis (weakness on the right side of the body), hypertension (HTN-high blood pressure), and congestive heart failure (CHF).	01640		

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01640	Continued From page 24 On October 28, 2025, at 7:44 a.m., the surveyor observed ULP-H complete a transfer for R8 from bed to commode. R8's service plan dated October 28, 2025, did not include a resident or resident representative signature and a licensee signature or other authentication by the licensee to document agreement on the services to be provided. On October 29, 2025, at 10:33 a.m., clinical nurse supervisor (CNS)-B stated CNS-B had just printed R8's service plan yesterday (October 28, 2025) after the surveyor requested R8's service plan, and CNS-B had not obtained any signatures to agree upon services provided. The licensee's Nursing Policy/Procedure- Service Plan policy dated October 29, 2025, indicated the service plan will include a description of the services that are to be provided based on the most recent assessment and resident preferences. In addition, the service plan and any revisions shall include a signature or other authentication by (licensee name) and by the resident, or resident's representative, documenting agreement on the services to be provided. 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	01760		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST SENIOR LIVING	311 BROADWAY AVENUE NE RED LAKE FALLS, MN 56750

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01760	Continued From page 25 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 accurately transcribe the prescriber orders onto the electronic medication administration record (EMAR) for one of three residents (R10). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on October 27, 2025, at 10:35 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management to residents at the facility. R10's diagnoses included diabetes, hypertension	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31767	A. BUILDING: _____ B. WING _____	10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST SENIOR LIVING	311 BROADWAY AVENUE NE RED LAKE FALLS, MN 56750

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01760	Continued From page 26 (HTN- high blood pressure), and chronic heart failure. R10's Service Plan - Waiver3 [sic]- MN (Minnesota) dated February 27, 2024, indicated R10's services included medication administration four times per day. On October 28, 2025, at 11:28 a.m., the surveyor observed unlicensed personnel (ULP)-F complete a blood glucose reading for R10. R10's prescriber orders dated October 13, 2025, included an order for Bumetanide (for chronic heart failure) 2 milligram (mg) tablet take 1 mg (1/2 tablet) by mouth daily. R10's Med (medication) Admin (administration) Summary - Month dated October 2025, indicated R10 was administered Bumetanide 2 mg tablet take one tablet by mouth once daily October 22, 2025, through October 28, 2025. Listed next to the scheduled medication column indicated Strength: 1 mg. R10's EMAR lacked the correct transcription from R10's prescriber orders for Bumetanide. On October 29, 2025, at 10:36 a.m., CNS-B stated the online pharmacy scripts synced the R10's EMAR did not transcribe R10's Bumetanide correctly, CNS-B had not caught the error on R10's EMAR, and CNS-B had to manually change some of the pharmacy scripts on resident EMARs that did not transcribe correctly. CNS-B further stated R10 had received the correct amount of Bumetanide after CNS-B reviewed R10's Bumetanide pharmacy label in the medication cart.	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31767	A. BUILDING: _____ B. WING _____	10/29/2025

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01760	Continued From page 27 A policy was requested, however, was not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care must meet the requirements of section 144G.45 and the following additional requirements: (1) an assessment of safety risks must be performed on and around the property. The safety risks identified by the facility on the assessment must be mitigated to protect the residents from harm. The mitigation efforts must be documented in the facility's records; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property for the facility. This deficient practice had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	02040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31767	A. BUILDING: _____ B. WING _____	10/29/2025

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02040	Continued From page 28 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). Findings include: A record review and interview were conducted on October 28, 2025, at 1:45 p.m. with director of maintenance (DM)-D on the hazard vulnerability assessment for the physical environment of the facility. During interview, DM-D stated that the licensee had performed a hazard assessment for the Appendix Z requirements but had not performed a hazard vulnerability assessment for the physical environment on or around the property. The hazard vulnerability assessment should include the risks factors and what the facility plans to do for a mitigation process. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		

Bemidji District Office
Minnesota Department of Health
705 5th St NW, Suite A
Bemidji, MN 56601
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

HILLCREST SENIOR LIVING
311 BROADWAY AVENUE NE
Red Lake Falls, MN 56750
Red Lake County
Parcel:

Phone:

License Info

License: HFID 31767

Risk:
License:
Expires on:
CFPM: GUY JOHNSON
CFPM #: FM115171; Exp: 01/31/2026

Inspection Info

Report Number: F8045251072
Inspection Type: Full - Single
Date: 10/28/2025 Time: 11:38:29 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 1
Total Priority 2 Orders: 1
Total Priority 3 Orders: 1
Delivery:

! **New Order: 2-300 Personal Cleanliness**
2-301.14B-G *Priority Level: Priority 1 CFP#: 8*
MN Rule 4626.0075B-G Food employees must wash their hands after: using the toilet; coughing or sneezing; using a handkerchief or disposable tissue; using tobacco; eating or drinking; handling soiled equipment or utensils; caring for or handling service animals or fish in an aquarium, molluscan shellfish or crustacea in a display tank; as frequently as necessary during food preparation to remove soil, contamination, and to prevent cross-contamination when changing food preparation tasks; when switching between working with raw food and working with RTE food; before donning gloves for working with food; and touching bare human body parts other than clean hands and clean exposed portions of arms.
COMMENT: OBSERVED NON-KITCHEN STAFF DONNING GLOVES TO ASSIST WITH FOOD DISTRIBUTION WITHOUT WASHING HANDS.
Comply By: Complied On Site Originally Issued On: 10/28/2025

New Order: 4-200 Equipment Design and Construction
4-201.11AMN *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0506A Provide or replace food service equipment with equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.
COMMENT: OBSERVED MAGIC BULLET BEING USED TO PREPARE HAMBURGER GRAVY FOR A PUREED DIET.
NSF FOOD PROCESSOR LOCATED DURING INSPECTION.
Comply By: Complied On Site Originally Issued On: 10/28/2025

New Order: 4-300 Equipment Numbers and Capacities
4-302.14 *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.
COMMENT: KITCHEN STAFF WERE USING CHLORINE SANITIZER AT TIME OF INSPECTION WITHOUT A TEST KIT AVAILABLE.

STAFF SWITCHED BACK TO QUAT DURING INSPECTION AND HAD A TEST KIT AVAILABLE.
Comply By: Complied On Site Originally Issued On: 10/28/2025

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Bemidji District Office inspection report number F8045251072 from 10/28/2025

Adam J Bommersbach

Establishment Representative

Adam Bommersbach,
Public Health Sanitarian 3
218-308-2147
adam.bommersbach@state.mn.us

Bemidji District Office
Minnesota Department of Health
705 5th St NW, Suite A
Bemidji, MN 56601

Temperature Observations/Recordings

Establishment Info

HILLCREST SENIOR LIVING
Red Lake Falls
County/Group: Red Lake County

Inspection Info

Report Number: F8045251072
Inspection Type: Full
Date: 10/28/2025
Time: 11:38:29 AM

Food Temperature: Product/Item/Unit: NOODLE GOULASH**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 35 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: HAMBURGER GRAVY**; Temperature Process:** Hot-Holding
Location: Warmer at 180 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: BOILED POTATO**; Temperature Process:** Cooking
Location: Stove Top at 190 Degrees F.
Comment:
Violation Issued?: No

Bemidji District Office
Minnesota Department of Health
705 5th St NW, Suite A
Bemidji, MN 56601

Sanitizer Observations/Recordings

Establishment Info

HILLCREST SENIOR LIVING
Red Lake Falls
County/Group: Red Lake County

Inspection Info

Report Number: F8045251072
Inspection Type: Full
Date: 10/28/2025
Time: 11:38:29 AM

Sanitizing Chemical: **Product:** Chlorine**; Sanitizing Process:** Wiping Cloth Bucket
Location: 3-Comp Sink **Equal To** 100 PPM
Comment:
Violation Issued?: No

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** Dispenser
Location: 3-Comp Sink **Equal To** 400 PPM
Comment:
Violation Issued?: No

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