Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

May 26, 2026

Licensee
Cornerstone Residence Senior Care
421 6th Street Northeast
Bagley, MN 56621

RE: Project Number(s) SL30775016

Dear Licensee:

On May 22, 2026, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on March 4, 2026. 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

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

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Electronically Delivered

March 26, 2026

Licensee
Cornerstone Residence Senior Care
421 6th Street Northeast
Bagley, MN 56621

RE: Project Number(s) SL30775016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 4, 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:

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

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30775	A. BUILDING: _____ B. WING _____	03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNERSTONE RESIDENCE SNR CARE	421 6TH STREET NE BAGLEY, MN 56621

(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: SL30775016-0 On March 2, 2026, through March 4, 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 27 residents; 27 receiving services under the Assisted Living Facility with Dementia Care license. An immediate correction order was identified on March 3, 2026, issued for SL30775016-0, tag identification 1290. The licensee took action on March 3, 2026, 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, 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 March 3, 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 ensure services were provided according to accepted health care, medical, or nursing standards in regard to infection control during resident cares for one of four employees (unlicensed personnel (ULP)-I). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 During the entrance conference on March 2, 2026, at 10:25 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided assistance with ADLs (activities of daily living) to residents at the facility. ULP-I's Relias (online training platform) Transcript indicated ULP-I completed training on Catheter and Perineal Care dated March 31, 2025, and Infection Control: Essential Principles dated April 30, 2025. On March 3, 2026, at 6:46 a.m., the surveyor observed ULP-I transfer R4 from toilet to wheelchair using a sit-to stand lift. ULP-I had on gloves, cleansed R4's perineal area, and pulled up R4's brief and pants. With the same gloved hands, ULP-I guided R4 into R4's chair, removed the sit-to stand sling from behind R4, brushed R4's hair, and placed R4's foot pedals onto R4's wheelchair. ULP-I proceeded to remove the garbage from the shared resident tub room, disinfected the toilet, returned R4's bathing and grooming supplies to R4's room, and made R4's bed. The surveyor did not observe ULP-I change gloves or complete hand hygiene after assisting R4 with toileting. On March 3, 2026, at 12:57 p.m., ULP-I stated ULP-I did not usually change gloves until all resident cares were completed and ULP-I had not changed ULP-I's gloves after completing R4's toileting. ULP-I further stated ULP-I was trained to complete hand hygiene before and after glove removal. On March 3, 2026, at 1:52 p.m., CNS-B stated ULPs were trained to change gloves and complete hand hygiene after assisting residents	0 510		

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0 510	Continued From page 5 with toileting. CNS-B further stated ULPs received infection control training upon hire and annually. The licensee's 8.09 Hand Washing policy dated August 1, 2021, indicated hand washing will be performed by all employees, as necessary, between tasks and procedures, and after bathroom use, to prevent cross-contaminations [sic]. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to	0 775		

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0 775	Continued From page 6 affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated March 2, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. 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	0 810		

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0 810	Continued From page 7 training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated March 2, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 810		

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01290	Continued From page 8	01290		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure current employee records contained all the required content to include a current background study clearance letter for two of eight employees (unlicensed personnel (ULP)-F, ULP-H). In addition, the licensee failed to affiliate an employee background study with the licensee's health care facility identification (HFID) number for one of one employee (cook (C)-G). 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	01290		

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01290	Continued From page 9 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 March 3, 2026. During the entrance conference on March 2, 2026, at 10:37 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated the licensee was aware of required contents in an employee record. NO BACKGROUND STUDY ULP-F ULP-F was hired on March 21, 2023, to provide direct care services to residents at the facility. ULP-F's Employee Timesheet dated December 27, 2025, through January 9, 2026, indicated ULP-F had worked over 23 hours for the licensee. ULP-F's employee record contained a cleared background study dated March 22, 2023, however, ULP-F was separated from the licensee's NETStudy 2.0 Roster on April 6, 2023, for an unknown reason. ULP-H ULP-H was hired on June 12, 2023, to provide direct care services to residents at the facility. ULP-H's Employee Timesheet dated November 29, 2025, through December 12, 2025, indicated ULP-H had worked over seven hours for the licensee. ULP-F and ULP-H's employee records lacked a	01290		

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01290	Continued From page 10 current cleared background study with the licensee. BACKGROUND STUDY AFFILIATION C-G was hired on April 24, 2023, to cook for residents at the facility. C-G's Employees Timesheet dated February 7, 2026, through February 20, 2026, indicated C-F had worked over 13 hours for the licensee. C-G's employee record contained a cleared background study dated with the licensee's sister facility HFID dated April 20, 2023. C-G's employee record lacked a cleared background study with the licensee's HFID 30775. On March 2, 2026, at 2:06 p.m., LALD-A stated LALD-A was responsible for entering background studies on the NETStudy 2.0 website and completed background studies upon hire. The surveyor reviewed the licensee's NETStudy 2.0 Roster with LALD-A. LALD-A stated ULP-F, ULP-H, and C-E were current part-time employees of the licensee and were not listed on the licensee's NETStudy 2.0 Roster. On March 2, 2026, at 3:36 p.m., regional licensed assisted living director (RLALD)-E stated LALD-A was responsible for completing background checks upon hire. RLALD-E stated all current employees were supposed to have a cleared background check with the licensee's HFID 30775, and RLALD-E was checking with other administration regarding ULP-F and ULP-H's background studies. RLALD-E further stated C-G was hired at a sister location and C-G's background study was not affiliated with the	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30775	A. BUILDING: _____ B. WING _____	03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNERSTONE RESIDENCE SNR CARE	421 6TH STREET NE BAGLEY, MN 56621

(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
01290	Continued From page 11 licensee's HFID. On March 2, 2026, at 3:53 p.m., RLALD-E stated RLALD-E was not sure what happened with ULP-F and ULP-H's background studies, and RLALD-E was unable to ensure if ULP-F or ULP-H had worked alone unsupervised with residents at the facility. The licensee's 4.02 Background Studies policy dated August 12, 2024, indicated using the MN (Minnesota) DHS (Department of Human Services) NetStudy online program, (licensee name) will initiate a background study on all employees being considered for hire. The policy further indicated new hires shall not be permitted to interact or provide services to tenants or clients (residents) of (licensee name) except under the direct supervision (eyesight) of another qualified staff person. The policy did not address background study affiliation. 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 until the entity is	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30775	A. BUILDING: _____ B. WING _____	03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNERSTONE RESIDENCE SNR CARE	421 6TH STREET NE BAGLEY, MN 56621

(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
01290	Continued From page 12 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		
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	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30775	A. BUILDING: _____ B. WING _____	03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNERSTONE RESIDENCE SNR CARE	421 6TH STREET NE BAGLEY, MN 56621

(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
01620	Continued From page 13 needs; and (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 resident reassessment and monitoring completed by a registered nurse (RN) was conducted no more than 14 calendar days after initiation of services for one of two residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30775	A. BUILDING: _____ B. WING _____	03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNERSTONE RESIDENCE SNR CARE	421 6TH STREET NE BAGLEY, MN 56621

(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
01620	Continued From page 14 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 March 2, 2026, at 10:52 a.m., clinical nurse supervisor (CNS)-B stated the licensee completed resident assessments prior to admission, on admission, within 14 days of admission, and then at least every 90 days or with a resident change of condition. R3 was admitted to the facility on October 2, 2025. R3's Comprehensive RN Assessment (admission assessment) dated October 2, 2025, was completed by CNS-B. On March 3, 2026, at 9:00 a.m., the surveyor observed unlicensed personnel (ULP)-K administer R3's scheduled morning medication. R3's record contained a Monitoring and Reassessment (14-day assessment) dated October 17, 2026, was completed by an RN, however, was completed 15 days after R3 was admitted to the facility. R3's record lacked a 14-day assessment conducted no more than 14 calendar days after the initiation of services. On March 4, 2026, at 11:16 a.m., CNS-B stated R3's 14-day assessment was entered into R3's electronic medical record on October 17, 2026, however, CNS-B stated the RN had completed	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01620	Continued From page 15 R3's 14-day assessment October 16, 2026, on paper. CNS-B further stated CNS-B was unable to locate the paper copy of R3's 14-day assessment completed on October 16, 2026. The licensee's 6.01 Assessments, Reviews and Monitoring policy dated August 1, 2021, indicated resident reassessment and monitoring must be conducted more than 14 calendar days after initiation of services. The licensee's 6.02 Assessment Schedules policy dated August 1, 2021, indicated a resident reassessment and monitoring would be completed by an RN and occur no more than 14 calendar days after the initiation of services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities.	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30775	A. BUILDING: _____ B. WING _____	03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNERSTONE RESIDENCE SNR CARE	421 6TH STREET NE BAGLEY, MN 56621

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01640	Continued From page 16 (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 included a licensee signature or other authentication by the licensee to document agreement on the services to be provided for one of three residents (R5). 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 March 2, 2026, at 9:24 a.m., licensed assisted living director (LALD)-A stated the licensee was familiar with current minimum assisted living requirements. R5's diagnoses included dementia and major depressive disorder. On March 3, 2026, at 8:07 a.m., the surveyor	01640		

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01640	Continued From page 17 observed unlicensed personnel (ULP)-J administer R5's scheduled morning medication. R5's Service Plan dated May 6, 2025, lacked a licensee signature or authentication by the licensee to document agreement on the services to be provided. On March 3, 2026, at 1:58 p.m., clinical nurse supervisor (CNS)-B stated resident service plans were supposed to be signed by the registered nurse (RN) any time a change was made to the service plan, however, the licensee's previous RN did not sign R5's service plan. The licensee's 6.06 Service Plan policy dated August 1, 2021, indicated 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		

Bemidji District Office
Minnesota Department of Health
706 5th St NW, Suite A
Bemidji, MN 56601
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Cornerstone Residence Senior Care
421 6th Street NE
Bagley, MN 56621
Clearwater County
Parcel:

Phone:

License Info

License: HFID 30775

Risk:
License:
Expires on:
CFPM: Kristi Mae Girtz
CFPM #: 21136; Exp: 8/3/2028

Inspection Info

Report Number: F1002261024
Inspection Type: Full - Joint
Date: 3/3/2026 Time: 11:00:00 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 3
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

! New Order: 3-200B Food Characteristics:Receiving: temperature, condition
3-202.11D *Priority Level: Priority 1 CFP#: 12*
MN Rule 4626.0165D Discontinue sale or service of TCS hot food not received at a temperature of 135 degrees F (57 degrees C) or above.
COMMENT: CHICKEN STRIPS AND MECHANICAL PORK RECEIVED FROM ADJOINING FACILITY WERE MEASURED TO BE 121 dF AND 104 dF, RESPECTIVELY. STAFF REHEATED THE ITEMS PRIOR TO SERVICE.
Comply By: 3/3/2026 Originally Issued On: 3/3/2026

! 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: A JUG OF MILK IN THE MEMORY CARE UNIT REFRIGERATOR WAS MEASURED TO BE 47 DEGREES F. HOWEVER, THE TEMPERATURE OF THE UNIT WAS FOUND TO BE 36 dF INDICATING THAT THE TEMPERATURE ABUSE IS OCCURRING AS A RESULT OF THE JUG OF MILK BEING REMOVED FROM THE REFRIGERATOR FOR TOO LONG. MDH OBSERVED THE SAME ISSUE IN THE MAIN DINING AREA AS WELL. INSTRUCTED STAFF TO DISCARD THE JUGS OF MILK AND DISCONTINUE ALLOWING THE TCS BEVERAGES SIT AT ROOM TEMPERATURE DURING SERVICE.
Comply By: 3/3/2026 Originally Issued On: 3/3/2026

! New Order: 4-500 Equipment Maintenance and Operation
4-501.114C3 *Priority Level: Priority 1 CFP#: 16*
MN Rule 4626.0805C3 Provide and maintain an approved quaternary ammonium compound sanitizing solution in water with 500 ppm hardness or less, a minimum temperature of 75 degrees F (24 degrees C) and a concentration specified in 21CFR.178.1010 and as indicated by the manufacturer's use directions and label.
COMMENT: THE CONCENTRATION OF THE QA SANITIZING SOLUTION THAT IS PROVIDED AT THE DISPENSER/3 COMP SINK WAS MEASURED TO BE 100 PPM AT TIME OF INSPECTION. INSTRUCTED STAFF TO INCREASE THE AMOUNT OF QA CONCENTRATION IN THE SOLUTION. INSTRUCTED STAFF TO PROVIDE AND USE CORRECT TEST STRIPS FOR THE PRODUCT.
Comply By: 3/3/2026 Originally Issued On: 3/3/2026

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 Bemidji District Office inspection report number F1002261024 from 3/3/2026

Kristi Girtz
Assisted Living Director

Cassandra Hua, REHS
Public Health Sanitarian 3
218-308-2142
cassandra.hua@state.mn.us

Bemidji District Office
Minnesota Department of Health
706 5th St NW, Suite A
Bemidji, MN 56601

Temperature Observations/Recordings

Establishment Info

Cornerstone Residence Senior Care
Bagley
County/Group: Clearwater County

Inspection Info

Report Number: F1002261024
Inspection Type: Full
Date: 3/3/2026
Time: 11:00:00 AM

Food Temperature: Product/Item/Unit: CHICKEN STRIPS, MECHANICAL PORK**; Temperature Process:** Receiving
Location: Counter at 104-121 Degrees F.
Comment: RECEIVING TEMPERATURE LOW - STAFF REHEATED THE ITEMS PRIOR TO SERVING.
Violation Issued?: Yes

Food Temperature: Product/Item/Unit: MILK**; Temperature Process:** Cold-Holding
Location: DOMESTIC REFRIGERATOR at 47 Degrees F.
Comment: MEMORY CARE UNIT
Violation Issued?: Yes

Food Temperature: Product/Item/Unit: MILK**; Temperature Process:** Cold-Holding
Location: Counter at 47 Degrees F.
Comment:
Violation Issued?: Yes

Food Temperature: Product/Item/Unit: MILK**; Temperature Process:** Cold-Holding
Location: ARCTIC AIR COOLER at 41 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: PORK LOIN, MASHED POTATOES, CAULIFLOWER, GRAVY**; Temperature Process:** Receiving
Location: Counter at 135+ Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: AMBIENT TEMP**; Temperature Process:**
Location: WALK IN FREEZER at 0 Degrees F.
Comment: FROZEN SOLID
Violation Issued?: No

Food Temperature: Product/Item/Unit: CHEESE**; Temperature Process:** Cold-Holding
Location: WALK IN COOLER at 39 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: PROTEIN SHAKE**; Temperature Process:** Cold-Holding
Location: DOMESTIC REFRIGERATOR at 36 Degrees F.
Comment: MEMORY CARE UNIT
Violation Issued?: No

Bemidji District Office
Minnesota Department of Health
706 5th St NW, Suite A
Bemidji, MN 56601

Sanitizer Observations/Recordings

Establishment Info

Cornerstone Residence Senior Care
Bagley
County/Group: Clearwater County

Inspection Info

Report Number: F1002261024
Inspection Type: Full
Date: 3/3/2026
Time: 11:00:00 AM

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

Sanitizing Chemical: **Product:** Chlorine**; Sanitizing Process:** Dish Machine
Location: Kitchen **Equal To** 50 PPM
Comment:
Violation Issued?: No

Minnesota (MDH) Version
EH Manager; RPT: F1002261024

Food Establishment Inspection Report

Bemidji District Office
Minnesota Department of Health
706 5th St NW, Suite A
Bemidji, MN 56601

No. of Risk Factor/Intervention/Violations	3	Date: 3/3/2026
No. of Repeat Risk Factor/Intervention/Violations		Time: 11:00 AM
Score (optional)		Dur: min

Establishment:	Address:	City/State:	Zip:	Phone:
Cornerstone Residence Senior Care	421 6th Street NE	Bagley, MN	56621	
License/Permit #:	**Permit Holder:**	**Purpose of Inspection:**	**Est. Type:**	**Risk Category:**
HFID 30775		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

	Compliance Status		COS	R
	Time/Temperature Control for Safety			
18	N/O	Proper cooking time & temperatures		
19	N/O	Proper reheating procedures for hot holding		
20	N/A	Proper cooling time and temperature		
21	N/O	Proper hot holding temperatures		
22	OUT	Proper cold holding temperatures		
23	IN	Proper date marking & disposition		
24	N/A	Time as public health control;procedures & record		
	Consumer Advisory			
25	N/A	Consumer advisory provided for raw or undercooked foods		
	Highly Susceptible Populations			
26	IN	Pasteurized foods used; prohibited foods not offered		
	Food/Color Additives and Toxic Substances			
27	N/A	Food additives; approved & properly used		
28	IN	Toxic substances properly identified;stored;used		
	Conformance with Approved Procedures			
29	N/A	Compliance with variance, specialized processes & HACCP plan		

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

GOOD RETAIL PRACTICES

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

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

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

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

Person in Charge (signature)

Inspector (signature) Cassandra Hua

Follow-up: Follow-up Date:

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL30775016	**Date:** 3/2/2026
Facility Name: Cornerstone Residence Senior	
Facility Address: 421 6th St. NE Bagley, MN 56621	

☒ **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. Egress doors shall be readily operable from the egress side without the use of a key or special knowledge. [Minn. Stat. 144G.45 subd. 2; MSFC 1010.2]

   Comments: The patio door that goes out to a fenced patio in the memory care unit, had a padlock on it that required a key to open it. There were clasp locks on storage room doors in the memory care unit that stored the microwave and coffee pot. The lock was not operable from inside these rooms.

3. Controlled egress doors shall: unlock upon activation of either the automatic sprinkler system or smoke detection system, unlock upon loss of power controlling the lock, have the capability of being unlocked by a signal or switch from the fire command center, nursing station, or other approved location. [Minn. Stat. 144G.45 subd. 2; MSFC 1010.1.9.7]

   Comments: The emergency exit doors leading outside had a keypad that required a code to unlock the doors. When interviewed about the controlled egress locking system, director of maintenance (DM)-D stated that there was no manual override for the controlled egress locks in the memory care unit. These same doors do not have a release to unlock when the fire alarm system is activated.

4. Lighted matches, cigarettes, cigars or other burning object shall not be discarded in such a manner that could cause ignition of other combustible material. [Minn. Stat. 144G.45 subd. 2; MSFC 310.7]

   Comments: There was cigarette butts lying on the ground and by the building near the patio door that lead out to a courtyard in the memory care.

DEPARTMENT OF HEALTH

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Twenty One (21) days

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

   Comments: The licensee failed to develop the fire safety and evacuation plan (FSEP) with site specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan addressed staff as a whole with no specific directions on what staff should be doing when a fire safety emergency happens.

2. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. [Minn. Stat. 144G.45 subd.2]

   Comments: The licensee failed to develop the fire safety and evacuation plan (FSEP) with no unique or unusual needs for movement or evacuation for residents to take in the event of a fire or similar emergency. The plan directs staff to "remove all tenants from danger."