Electronically Delivered

September 17, 2025

Licensee
Bethesda North Pointe
500 Peterson Parkway
New London, MN 56273

RE: Project Number(s) SL38113016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 6, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

§ 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00

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

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

The correction order documentation should include the following:

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

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

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

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Kelly Thorson

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38113	A. BUILDING: _____ B. WING _____	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA NORTH POINTE	500 PETERSON PARKWAY NEW LONDON, MN 56273

(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: SL38113016-0 On August 4, 2025, through August 6, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 92 residents; 64 receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 130 SS=C	144G.12, Subd. 1 Application for Licensure Each application for an assisted living facility	0 130		

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0 130	Continued From page 1 license, including provisional and renewal applications, must include information sufficient to show that the applicant meets the requirements of licensure, including: (1) the business name and legal entity name of the licensee, and the street address and mailing address of the facility; (2) the names, e-mail addresses, telephone numbers, and mailing addresses of all owners, controlling individuals, managerial officials, and the assisted living director; (3) the name and e-mail address of the managing agent and manager, if applicable; (4) the licensed resident capacity and the license category; (5) the license fee in the amount specified in section 144.122; (6) documentation of compliance with the background study requirements in section 144G.13 for the owner, controlling individuals, and managerial officials. Each application for a new license must include documentation for the applicant and for each individual with five percent or more direct or indirect ownership in the applicant; (7) evidence of workers' compensation coverage as required by sections 176.181 and 176.182; (8) documentation that the facility has liability coverage; (9) a copy of the executed lease agreement between the landlord and the licensee, if applicable; (10) a copy of the management agreement, if applicable; (11) a copy of the operations transfer agreement or similar agreement, if applicable; (12) an organizational chart that identifies all organizations and individuals with an ownership interest in the licensee of five percent or greater	0 130		

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0 130	Continued From page 2 and that specifies their relationship with the licensee and with each other; (13) whether the applicant, owner, controlling individual, managerial official, or assisted living director of the facility has ever been convicted of: (i) a crime or found civilly liable for a federal or state felony level offense that was detrimental to the best interests of the facility and its resident within the last ten years preceding submission of the license application. Offenses include: felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions; financial crimes such as extortion, embezzlement, income tax evasion, insurance fraud, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions; any felonies involving malpractice that resulted in a conviction of criminal neglect or misconduct; and any felonies that would result in a mandatory exclusion under section 1128(a) of the Social Security Act; (ii) any misdemeanor conviction, under federal or state law, related to: the delivery of an item or service under Medicaid or a state health care program, or the abuse or neglect of a patient in connection with the delivery of a health care item or service; (iii) any misdemeanor conviction, under federal or state law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service; (iv) any felony or misdemeanor conviction, under federal or state law, relating to the interference with or obstruction of any investigation into any criminal offense described in Code of Federal Regulations, title 42, section 1001.101 or	0 130		

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0 130	Continued From page 3 1001.201; (v) any felony or misdemeanor conviction, under federal or state law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance; (vi) any felony or gross misdemeanor that relates to the operation of a nursing home or assisted living facility or directly affects resident safety or care during that period; (vii) any revocation or suspension of a license to provide health care by any state licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a state licensing authority; (viii) any revocation or suspension of accreditation; or (ix) any suspension or exclusion from participation in, or any sanction imposed by, a federal or state health care program, or any debarment from participation in any federal executive branch procurement or nonprocurement program; (14) whether, in the preceding three years, the applicant or any owner, controlling individual, managerial official, or assisted living director of the facility has a record of defaulting in the payment of money collected for others, including the discharge of debts through bankruptcy proceedings; (15) the signature of the owner of the licensee, or an authorized agent of the licensee; (16) identification of all states where the applicant or individual having a five percent or more ownership, currently or previously has been licensed as an owner or operator of a long-term care, community-based, or health care facility or agency where its license or federal certification has been denied, suspended, restricted, conditioned, refused, not renewed, or revoked	0 130		

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0 130	Continued From page 4 under a private or state-controlled receivership, or where these same actions are pending under the laws of any state or federal authority; (17) statistical information required by the commissioner; and (18) any other information required by the commissioner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to apply for increased capacity to meet the requirements of licensure. This had the potential to affect all of the licensee's residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect 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: The licensee's Application for Assisted Living License signed July 11, 2024, identified an application for an assisted living with dementia care license with a total licensed resident capacity for eighty-four (84) residents. During the entrance conference on August 4, 2025, at 9:00 a.m., licensed assistance living director (LALD)-A stated the licensee had a current census of ninety-one (91) residents, with forty-six (46) residents who were receiving services. Vice President (VP)-C stated that he had an approval for a variance for the addition of their independent living.	0 130		

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0 130	Continued From page 5 On August 4, 2025, at 10:29 a.m. surveyor requested for the approval for the licensee's increased census. On August 4, 2025, at 10:32 a.m. LALD-A provided an Assisted Living Licensure Innovation Variance Request form dated June 30, 2025, for an approved separation of the area of the building identified in the variance on the other side of the 2-hour fire barrier. On August 4, 2025, at 9:45 a.m., surveyor was led in a facility tour by LALD-A. The first floor was being used as an assisted living, independent living and a locked dementia care unit. The second floor was being used as independent living on one wing connected to assisted living and independent care by open fire doors. The new addition of the independent living had ten occupied units. On August 4, 2025, at 10:40a.m., surveyor reviewed licensee's current resident roster with eighteen (18) residents in the locked dementia unit; forty-six (46) residents in the assisted living with services, and twenty-eight (28) residents in the independent care; with a total capacity of ninety-two (92) residents. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 130		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food	0 480		

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0 480	Continued From page 6 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 allowed provided the facility keeps them clean	0 480		

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0 480	Continued From page 7 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 August 4, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer	0 480		

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0 480	Continued From page 8 to the FBEIR for any compliance dates.	0 480		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) and Minnesota Department of Health (MDH), including completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for one of two employees (unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at an	0 660		

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0 660	Continued From page 9 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: The licensee's Facility TB Risk Assessment Worksheet for Health Care Settings Licensed by MDH was completed on July 1, 2025, and the facility was determined to be a low risk level. ULP-D was hired February 27, 2024, and provided direct cares and services for residents of the facility. On August 5, 2025, at 8:23 a.m., the surveyor observed ULP-D assisting resident with blood glucose and medication administration. ULP-D's employee record contained a negative Baseline TB Screening Tool for Healthcare Workers (HCWs) dated March 27, 2025. ULP-D's employee record contained a negative two-step TST dated March 29, 2025, and April 19, 2024 (29 days after hired date). On August 6, 2025, at 9:53 a.m., clinical nurse supervisor (CNS)-B stated ULP-D was working on the floor with supervision prior to March 27, 2025. On August 6, 2025, at 12:52 p.m. licensed assisted living director (LALD)-A stated they were unaware why ULP-D was not tested for TB upon hire. The licensee's TB Prevention and Control policy dated August 27, 2024, read; "At time of hire and	0 660		

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0 660	Continued From page 10 prior to any contact with residents, all assisted living employees and all volunteers will be screened for Tuberculosis. -Prior to contact with residents, the RN will review TB symptoms with each new assisted living employee and with any volunteers having direct resident contact. -Prior to contact with residents, each staff person will be screened for TB. A two-step skin test or single interferon gamma release assay (IGRA) for M. tuberculosis (e.g., QuantiFERON® TB Gold or TB Gold-InTube, TSPOT ®.TB) will be administered unless the person's past medical history indicates that a TB skin test is contraindicated. Individuals who have been vaccinated with Bacillus Calmette-Guerin (BCG) vaccine are not exempt from tuberculin skin testing. Pregnant women are not exempt from tuberculin skin testing unless they have filed the exemption form for TB skin testing of a pregnant health care worker. The RN will follow the MDH guidance in 06-009 regarding how to screen employees with a previous or current positive TST or TB blood test or with a documented history of previous treatment for latent TB infection (LTBI) or active TB disease." The Regulations for TB Control in Minnesota Health Care Settings dated July 2013, indicated a baseline TB screening is required for all HCWs upon hire, and included administering a two-step TST or single blood draw to screen for active TB. The MDH TB Screening and Education Requirements for Assisted Living Facilities and Home Care Providers dated February 3, 2022, indicated baseline TB screening is required at the time of hire for all health care personnel in Minnesota. Baseline TB screening includes assessing for current symptoms of active TB	0 660		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 660	Continued From page 11 disease; assessing TB history; and testing for the presence of infection with Mycobacterium TB by administering either a two-step TB skin test or a single TB blood test. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
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). Findings include: On a facility tour on August 04, 2025, from 11:20 a.m. to 12:35 p.m., with vice president (VP)-C, the surveyor made the following observations of non-compliance with the requirements of the	0 775		

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	38113	A. BUILDING: _____ B. WING _____	08/06/2025

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0 775	Continued From page 12 Minnesota State Fire Code (MSFC) in Minnesota Rules Chapter 7511: EXIT DOOR LOCKING ARRANGEMENTS There was a controlled egress locking system installed on the emergency exit doors in the memory care unit leading to the exterior exit path. The controlled egress door locking system was not provided with a device capable of deactivating the delayed egress door hardware to the unlocked position from the nurse station or other approved location for occupants to exit in the event of an emergency. The controlled egress locking system is required 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. Emergency Exit Door to courtyard On August 04, 2025, at 11:45 a.m., survey staff toured the facility with vice president (VP)-C, it was observed that the emergency exit door in the memory care exited out into the courtyard that was fenced in with a gate that was locked. This removes a safe means of egress during a fire or similar emergency. This emergency exit door was identified with overhead exit signs and are included in the facility's evacuation plan. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		

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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 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.	01060		

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01060	Continued From page 14 (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 a written notice with the required content for an emergency relocation to the resident, their legal representative, and designated representative for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R1's service plan, dated June 26, 2025, indicated R1 received services including assistance with medication administration, dressing grooming, bathing, hearing assist, TED stockings, skin care, safety checks, laundry and toileting assist. On August 5, 2025, at 7:30 a.m., unlicensed personnel (ULP)-E was observed assisting R1 with dressing, grooming, toileting, peri cares, hearing assist, TED stocking, skin care and medication administration. R1's progress note, dated July 22, 2025, at 2:02 p.m., by registered nurse (RN)-F, indicated R1	01060		

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01060	Continued From page 15 returned from the ER after a fall. R1 "was taken by EMS to the ER post fall for an x-ray of pelvis, UA, CT of head ECG, CBC, PT/INR, Mg, CBC and Troponin." R1's record lacked documentation a written notice was provided to the resident, their legal representative, and their designated representative with the following required information: -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 Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; -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. On August 5, 2025, at 1:59 a.m., licensed assisted living director (LALD)-A stated an emergency relocation was not performed because R1 came back the same day. LALD-A stated they do not send an emergency relocation unless they know if the resident will be hospitalized. On August 6, 2025, R1's Post Fall Assessment dated July 22, 2025, read resident was seen in the ER on July 21, 2025.	01060		

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01060	Continued From page 16 The licensee's Emergency Relocation policy dated October 16, 2023, read: "The facility must issue a notice when a resident has an emergency relocation. The notice must include specific information and be sent to specified individuals. The notice must include the following: -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 Office of Ombudsman for Long-Term Care; -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 the return date is not currently known; and -A statement that, if the facility refuses to provide housing or services after 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. The notice required must be delivered as soon as practicable to: -The resident, legal representative, and designated representative; -For residents who receive home and community-based waiver services, the resident's case manager; and -The Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		

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01500	Continued From page 17	01500		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss.	01500		

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01500	Continued From page 18 Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received at least eight (8) hours of annual training for each 12 months of employment for one of two employees (unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-D was hired February 27, 2024, and provided direct cares and services for residents	01500		

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01500	Continued From page 19 of the facility. On August 6, 2025, at 12:29 p.m. surveyor reviewed ULP-D's employee record with the education for principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person completed on April 1, 2024. ULP-D's employee record lacked annual required training in the following topics: All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On August 6, 2025, at 12:50 p.m., licensed assisted living director (LALD)-A stated they would check with their human resource department as they are unaware why this education was missed. The licensee's Required Annual Training policy dated October 2023, read: "All staff that perform direct services must complete at least eight (8) hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. Licensee shall retrain evidence in the personnel record of each staff member having completed the training. The annual training must include: -Principles of person-centered planning and	01500		

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01500	Continued From page 20 service delivery and how they apply to direct support services provided by staff person." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for one of one resident (R1) with a consumer side rail. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 the residents). The findings include: On August 5, 2025, at 8:39 a.m., the surveyor observed R1's consumer side rail on the right	02310		

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02310	Continued From page 21 side of his bed and his left side of his bed up against the wall. R1 was admitted and began receiving services on the dementia locked care unit on January 9, 2025. R1's service plan, dated June 26, 2025, indicated R1 received services including assistance with medication administration, dressing grooming, bathing, hearing assist, TED stockings, skin care, safety checks, laundry and toileting assist. R1's consumer side rail assessment dated July 22, 2025, lacked documented side rail manufacture guidelines. On August 6, 2025, at 11:15 a.m., surveyor, clinical nurse supervisor (CNS)-B and registered nurse (RN)-F observed R1's consumer side rail and noted there was no strap attached to the side rail and mattress. RN-F stated that she did not have the manufacture guidelines for R1's side rail and searched Amazon website for a similar side rail. RN-F stated that a CPSC was reviewed with the initial installation and is not reviewed upon each 90-day assessment. CNS-B and RN-F stated they were not aware of the requirements for consumer side rails. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) last updated August 6, 2025, read, "Unlike hospital beds, there is no current published guidance related to portable bed rails used on non-hospital style beds ("consumer beds"), so licensees should refer to individual manufacturer's guidelines for appropriate installation, maintenance and use. In addition, licensees should refer to the Consumer	02310		

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02310	Continued From page 22 Product Safety Commission (CSPC) for the most up-to-date information related to portable bed side rail recall information. One such element/performance/skill a prudent nurse performs is the documentation of all assessed data. If any aspect of patient care is not documented, it is viewed as not having been completed. Based on the above-mentioned statutes, the nurse must also abide by accepted health care standards, and the use of portable bed rails according to manufacturer's guidelines is one of those accepted standards. Documentation about a resident's bed rails includes, but is not limited to: -Purpose and intention of the bed rail -Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail -The resident's bed rail use/need assessment -Risk vs. benefits discussion (individualized to each resident's risks) -The resident's preferences -Installation and use according to manufacturer's guidelines -Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation -Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed	02310		

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02310	Continued From page 23 without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint. Additionally, the licensee must ensure the bed rail is securely attached to the bed frame per manufacturer guidelines. This includes consideration of any identified contradictions of use such as height/weight restrictions, age, mattress, bed frame set up, etc." The licensee's undated Bed Rail Assessment policy read; " The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. -483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. -483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. -483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. -483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. -Hospital beds: follow the FDA guidelines for bed rail safety, assess whether the device is appropriate for the individual, and educate the individual on the risks versus benefits of the device. -Other assistive devices attached to beds: Know whether the device has been recalled by the CPSC and whether the device is installed according to manufacturer's guidelines. -Assess whether the device is appropriate for the resident or client, considering cognitive and physical status.	02310		

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02310	Continued From page 24 -Educate the resident on the risks versus benefits of the device -Every 90 days, check for recalls on other assistive devices attached to beds. Recalls | CPSC.gov." No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	02310		

St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

BETHESDA NORTH POINTE
500 PETERSON PARKWAY
New London, MN 56273
Parcel:

Phone:

License Info

License: HFID 38113

Risk:
License:
Expires on:
CFPM: Matt Beerman
CFPM #: 123334; Exp: 5/15/2027

Inspection Info

Report Number: F7930251080
Inspection Type: Full - Single
Date: 8/4/2025 Time: 11:15:21 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 1
Total Priority 2 Orders: 1
Total Priority 3 Orders: 1
Delivery: Emailed

! **New Order: 3-300B Protection from Contamination: cross-contamination, eggs**
3-302.11A(1) *Priority Level: Priority 1 CFP#: 15*
MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.
COMMENT: AT TIME OF INSPECTION, RAW SHELL EGGS WERE STORED ABOVE SHREDDED CHEESE IN THE UPRIGHT COOLER ON THE COOKLINE.
Comply By: Complied On Site Originally Issued On: 8/4/2025

New Order: 4-300 Equipment Numbers and Capacities
4-302.13B *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.
COMMENT: PROVIDE A MIN/MAX WATERPROOF THERMOMETER OR THERMO LABELS TO MONITOR THE FINAL RINSE CYCLES FOR THE DISHWASHERS IN THE MEMORY CARE KITCHEN AND THE ASSISTED LIVING KITCHEN.
Comply By: 8/11/2025 Originally Issued On: 8/4/2025

New Order: 6-300 Physical Facility Numbers and Capacities
6-301.14A *Priority Level: Priority 3 CFP#: 10*
MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands.
COMMENT: FOR BOTH HANDWASHING SINKS IN THE MEMORY CARE KITCHEN AND THE ASSISTED LIVING KITCHEN.
Comply By: 8/5/2025 Originally Issued On: 8/4/2025

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 St Cloud District Office inspection report number F7930251080 from 8/4/2025

Establishment Representative

Tina Remmele

Tina Remmele,
Public Health Sanitarian 3

320-223-7302
tina.remmele@state.mn.us

St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301

Temperature Observations/Recordings

Establishment Info

BETHESDA NORTH POINTE
New London
County/Group:

Inspection Info

Report Number: F7930251080
Inspection Type: Full
Date: 8/4/2025
Time: 11:15:21 AM

New Record: Product/Item/Unit: LIQUID PASTEURIZED EGGS**; Temperature Process:** Cold-Holding
Location: Upright Cooler--Near Cookline (Main Kitchen) at 40 Degrees F.
Comment:
Violation Issued?: No

New Record: Product/Item/Unit: STRING CHEESE**; Temperature Process:** Cold-Holding
Location: Upright Cooler--Near Dishwashing Room (Main Kitchen) at 40 Degrees F.
Comment:
Violation Issued?: No

New Record: Product/Item/Unit: MIXED GREENS**; Temperature Process:** Cold-Holding
Location: Walk-in Cooler--Main Kitchen at 37 Degrees F.
Comment:
Violation Issued?: No

New Record: Product/Item/Unit: STRING CHEESE**; Temperature Process:** Cold-Holding
Location: Upright Cooler--Memory Care at 40 Degrees F.
Comment:
Violation Issued?: No

New Record: Product/Item/Unit: MILK**; Temperature Process:** Cold-Holding
Location: Upright Cooler--Assisted Living at 41 Degrees F.
Comment:
Violation Issued?: No

St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301

Sanitizer Observations/Recordings

Establishment Info

BETHESDA NORTH POINTE
New London
County/Group:

Inspection Info

Report Number: F7930251080
Inspection Type: Full
Date: 8/4/2025
Time: 11:15:21 AM

New Record: **Product:** Quaternary Ammonia**; Sanitizing Process:** Wiping Cloth Bucket
Location: Prep Area--Main Kitchen **Equal To**
Comment: 200PPM
Violation Issued?: No

New Record: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Kitchen--Main **Equal To**
Comment: 164.1 DEG F
Violation Issued?: No

New Record: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Kitchen--Memory Care **Equal To**
Comment: 161.1 DEG F
Violation Issued?: No