Electronically Delivered

November 10, 2025

Licensee
Vitacare Living
540 East Isle Street
Isle, MN 56342

RE: Project Number(s) SL28438016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 22, 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 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

factor.

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

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

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

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

If you have any questions, please contact me.

Sincerely,

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

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28438	A. BUILDING: _____ B. WING _____	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING	540 EAST ISLE STREET ISLE, MN 56342

(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: SL28438016-0 On October 20, 2025, through October 22, 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 10 residents; all 10 receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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

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0 480	Continued From page 2 existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated October 20, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24	0 480		

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

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0 485	Continued From page 4 problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the facility tour with registered nurse (RN)-I on October 20, 2025, at 11:45 a.m., the surveyor observed a board in the dining room with the day's menu written. In addition, RN-I stated the kitchen door has a lock and resident's do not have access to the kitchen. On October 20, 2025, at 3:25 p.m., unlicensed personnel (ULP)-G and ULP-C stated the weekly menu was posted on the refrigerator in the kitchen, which the resident's do not have access to. ULP-G and ULP-C stated the daily menu was posted on the board in the dining room. On October 22, 2025, at 3:10 p.m., assisted living director in residency (ALDIR)-B stated the menu was typically posted in the dining room on the board with the wifi password, but must have been moved. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the	0 510		

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0 510	Continued From page 5 national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program to comply with accepted health care, medical, and nursing standards for infection control for one of one employee (unlicensed personnel/ULP-H). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On October 21, 2025, at 8:22 a.m., the surveyor observed ULP-H prepare blood glucose testing supplies from the medication cart and go to R2's room. With gloved hands, ULP-H wiped R2's middle left finger with an alcohol wipe, poked the finger with a lancet, placed the blood sample on the test strip. ULP-H then opened the resident's door, returned to the medication cart, recorded the result in the electronic record on the computer, touching the keyboard with gloved	0 510		

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0 510	Continued From page 6 hands, placed the lancet in the Sharps container, and at this time, removed the gloves and utilized hand sanitizer on his hands. On October 21, 2025, at 10:02 a.m., ULP-H stated he should have removed the gloves and performed hand hygiene immediately after placing the lancet in the Sharps container. On October 22, 2025, at 9:19 a.m., registered nurse (RN)-I stated staff were trained and expected to remove gloves and perform hand hygiene right after performing the glucometer test and prior to touching anything. The licensee's Hand Hygiene policy dated April 17, 2023, noted hands should be washed before and after direct contact with residents and after removing gloves or gowns. The Centers for Disease Control's (CDC), "CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings" dated April 12, 2024, under section 5a.1 indicated: 1.) Require healthcare personnel to perform hand hygiene in accordance with CDC recommendations. 2.) Use an alcohol-based hand rub or wash with soap and water for the following clinical indications: a.) Immediately before touching a patient; b.) Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices; c.) Before moving from work on a soiled body site to a clean body site on the same patient; d.) After touching a patient or the patient's immediate environment;	0 510		

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0 510	Continued From page 7 e.) After contact with blood, body fluids or contaminated surfaces; and f.) Immediately after glove removal. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 660 SS=E	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), which included completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for two of four	0 660		

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0 660	Continued From page 8 employees (unlicensed personnel/ULP-H, registered nurse/RN-I), and TB screening for one of four employees (ULP-H). In addition, the licensee failed to provide TB training on hire for one of four employees (ULP-H) and annually for one of four employees (RN-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 a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: The licensee's Facility TB Risk Assessment dated March 17, 2025, indicated the licensee was a low risk level. ULP-H ULP-H was hired on August 5, 2025, to provide direct care services to residents. On October 21, 2025, from 7:31 a.m. to 10:02 a.m., the surveyor observed ULP-H administer medications and prepare breakfast for residents at the facility. ULP-H's record included a Baseline TB Screening Tool for Healthcare Workers (HCWs) form that was blank and undated. It also included a TST administered on October 20, 2025, (76 days after hire). ULP-H's record lacked evidence of TB training at hire.	0 660		

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0 660	Continued From page 9 RN-I RN-I was hired on March 6, 2023, to provide direct care services to residents and to provide staff supervision at the facility. RN-I's record included a TST read on March 16, 2023, and March 30, 2023, both marked as negative. However it lacked documentation of the millimeters (mm) induration as required. RN-I's record also lacked documented evidence of annual TB training. On October 22, 2025, at 12:51 p.m., assisted living director in residency (ALDIR)-B stated RN-I had not completed the required TB training, and at 1:05 p.m., stated ULP-H had received the first TST after having contact with residents, and had not received TB training at hire. ALDIR-B stated the TB training had been assigned but not completed. The licensee's TB Prevention and Control policy dated April 17, 2023, noted staff would not work in resident care areas until a negative TB test was provided. It also noted staff would be educated on hire and annually on infection control including bloodborne pathogens. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated an employee may begin working with patients after a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in	0 660		

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0 660	Continued From page 10 the employee's record. In addition, it noted TST documentation should include the date of the test, the number of millimeters (mm) of induration (if no induration, document "0" mm) and the interpretation (positive or negative). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule.	0 680		

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0 680	Continued From page 11 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the required content defined in Appendix Z. This had the potential to affect residents receiving services under the assisted living license, 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, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On October 20, 2025, at 11:45 a.m., during the facility tour with registered nurse (RN)-I, the surveyor observed the building to have three floors, including a basement used for storage, a main floor with resident rooms, a kitchen, dining room, living room and bathrooms, and an upstairs with staff office and kitchen dry goods storage. The licensee's red emergency preparedness binder dated reviewed on April 27, 2023, lacked the following required content: - annual review/updates; - annual review of the risk assessment to include care related emergencies an interruption to normal supply of essential resources and medical	0 680		

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	28438	A. BUILDING: _____ B. WING _____	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING	540 EAST ISLE STREET ISLE, MN 56342

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0 680	Continued From page 12 supplies; - quarterly review of the missing resident plan; - EP training and testing program that must be reviewed and updated annually; - training program to include initial training of new staff and existing staff, individuals providing services under arrangement, and volunteers consistent with their expected role and at least annually; - exercises to test the EP at least twice per year, including unannounced staff drills using the EP to include: - participate in an annual full-scale exercise that is community based or conduct an annual, individual, facility-based functional exercise or if the facility experiences an actual emergency requiring activation of the plan, the facility is exempt from engaging in its next required full-scale exercise; - conduct an additional annual exercise that may include a second full-scale exercise that is community based or an individual, facility based functional exercise or mock disaster drill or table-top exercise; and - analyze the facility's response to and maintain documentation of all drills, tabletop exercises and emergency events and revise the plan as needed. On October 22, 2025, at 12:27 p.m., assisted living director in residency (ALDIR)-B stated the review of the emergency preparedness plan and hazard vulnerability assessment was to be done annually by the RN at the same time the facility tuberculosis (TB) risk assessment was completed. In addition, ALDIR-B stated she had yet to review the missing resident plan with the RN who has been doing it, and felt it should be done annually. ALDIR-B also stated a severe	0 680		

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0 680	Continued From page 13 weather occurrence happened where she called in and talked to staff about the action they needed to take, but this was not documented. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 700 SS=E	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure resident records were protected against unauthorized disclosure for five of ten residents (R5, R6, R7, R2) observed during medication administration. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).	0 700		

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0 700	Continued From page 14 The findings include: R5 R5's diagnoses included bilateral lower extremity deep vein thrombosis (DVT- a blood clot forms deep in a vein). R5's Service Plan dated October 6, 2025, indicated R5 received services including assistance with bathing, compression stockings, laundry, and medication administration. On October 21, 2025, at 7:31 a.m., the surveyor observed unlicensed personnel (ULP)-H set up medications for R5 at the medication cart in the dining room, and administer medications to R5 at the dining room table. At 7:35 a.m., ULP-H left the dining room to go down the hallway to check on another resident, leaving the computer screen open to R5's electronic medication administration record (MAR). At 7:44 a.m., ULP-H returned to the dining room, entered the kitchen to wash their hands and prepare breakfast for residents. Three residents were in the dining room during this entire time. R6 R6's diagnoses included atherosclerosis of the coronary artery (a build up of fats, cholesterol and other substances in and on the artery walls). R6's Service plan dated October 6, 2025, indicated R6 received services including assistance with laundry, bathing, and medication administration. On October 21, 2025, at 7:48 a.m., the surveyor observed ULP-H return to the medication cart to	0 700		

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0 700	Continued From page 15 prepare medications for R6. ULP-H then administered the medications to R6 at the dining room table, left the computer open and entered the kitchen. Four residents were in the dining room during this time. R7 R7's diagnoses included Charcot-Marie-Tooth disease (a group of disorders that cause nerve damage). R7's Service plan dated October 6, 2025, indicated R7 received services including assistance with bathing, compression stockings, dressing, and medication administration. On October 21, 2025, at 8:07 a.m., the surveyor observed ULP-H prepare medications for R7, and administered to R7 in the dining room. At 8:17 a.m., the surveyor observed ULP-H take an empty medication card upstairs to the office area, leaving the computer screen open. Three residents were in the dining room during this time. R2 R2's diagnoses included hypertension (high blood pressure). R2's Service Plan dated October 6, 2025, indicated R2 received services including assistance with bathing, blood glucose monitoring, and medication administration. On October 21, 2025, at 8:22 a.m., the surveyor observed ULP-H prepare blood glucose testing supplies from the medication cart and go to R2's room, leaving the computer open on the	0 700		

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0 700	Continued From page 16 medication cart. Two residents were in the dining room at this time. ULP-H returned to the medication cart after completing the blood glucose test, documented the results in the electronic medical record on the computer. From 8:30 a.m. to 8:32 a.m., ULP-H was upstairs, leaving the computer open. One resident was in the dining room at this time. At 8:40 a.m., ULP-H returned to R2's room to administer eye drops, leaving the computer open. One resident was in the dining room at this time. On October 21, 2025, at 10:02 a.m., ULP-H stated he forgot to close the computer when leaving the area, and should have done so. On October 22, 2025, at 9:14 a.m., registered nurse (RN)-I stated the computer screen should be closed each time staff leave the area. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 700		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history,	0 730		

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0 730	Continued From page 17 allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the	0 730		

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0 730	Continued From page 18 licensee failed to ensure the resident record included a discharge summary with the required content for one of one discharged resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R3's record lacked a discharge summary with a summary of the resident's stay that included: - diagnoses; - course of illnesses; - allergies; - treatments and therapies; - pertinent lab, radiology and consultation results; and - a final summary of the resident's status from the latest assessment or review including baseline and current medical, behavioral, and functional status. R3's diagnoses included congestive heart failure. R3 admitted to the facility on August 20, 2025, and discharged on September 12, 2025 R3's Service Plan dated September 9, 2025, indicated R3 received services including assistance with bathing and skin care. On October 22, 2025, at 3:05 p.m., assisted	0 730		

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0 730	Continued From page 19 living director in residency (ALDIR)-B stated a discharge summary had not been completed for R3 as required. The licensee's Discharge Summary policy dated April 17, 2023, noted a discharge summary would be completed by the time of discharge including diagnosis, course of illnesses, allergies, treatments, therapies, pertinent consultation results, and a final summary of the resident's status. No further information was provided. TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days	0 730		
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 provisions of Minnesota State Fire Code under MN Rules chapter 7511. This deficient condition had the ability to affect all staff and residents 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	0 775		

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0 775	Continued From page 20 failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 20, 2025, at approximately 1:00 p.m., the surveyor toured the facility with assisted living director in residency (ALDIR)-B. During the tour, the surveyor observed the following: 1. The egress window in BR 5 was sealed with clear tape from the inside, not allowing the egress window to properly open. 2. In bedroom 5 extension cords were present through out the bedroom, and outlets had 3-way plugs and extension cords. An approved surge protected power strip shall be used to prevent overloading of the electrical outlets. During the facility tour interview on October 20, 2025, ALDIR-B verified the observation while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 790 SS=C	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire	0 790		

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0 790	Continued From page 21 Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) 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 October 20, 2025, at approximately 1:00 p.m., the surveyor toured the facility with assisted living director in residency (ALDIR)-B. During the tour, the surveyor observed the following: The portable fire extinguishers lacked records to show monthly visual inspections were complete. Portable fire extinguishers must be provided monthly visual inspections of each extinguisher by their employees to ensure all portable extinguishers are readily available, fully charged, and operable at their designated location with no obvious physical damage or condition to the extinguisher that would prevent their operation when needed. During the facility tour interview on October 20,	0 790		

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0 790	Continued From page 22 2025, ALDIR-B verified the observation while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a 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).	0 800		

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0 800	Continued From page 23 The findings include: On October 20, 2025, at approximately 1:00 p.m., the surveyor toured the facility with assisted living director in residency (ALDIR)-B. During the tour, the surveyor observed the following: GENERAL MAINTENANCE: The sink in the kitchen/dinning room area was cracked in the bowl. This has the potential to create an unsanitary condition or even injury to staff and residents. The flooring in the hallway was in disrepair in spots. This has the potential to create a tripping hazard to staff and residents. The water heater in the lower level was leaking leaving a large pool of water in the lower level. During the facility tour interview on October 20, 2025, ALDIR-B verified the observation while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency;	0 810		

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0 810	Continued From page 24 (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 810		

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0 810	Continued From page 25 safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: October 20, 2025, assisted living director in residency (ALDIR)-B, provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP failed to include the following: The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. On October 20, 2025, ALDIR-B stated they understood the need for a resident policy and would work to create a new policy. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. ALDIR-B lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. On October 20, 2025, ALDIR-B stated they understood the requirements for training	0 810		

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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
0 810	Continued From page 26 residents and would implement a training program that was compliant with statute requirements. DRILLS: The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Record review of licensee's evacuation drill log, indicated evacuation drills were conducted for only AM shifts on April 28, 2025, July 16, 2025, and a combined AM & PM drill on August 15, 2025, with no trainings for overnight staff. Fire drills are required for staff twice per year per shift with at least one per month. On October 20, 2025, ALDIR-B stated they understood the requirements for the fire drills. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 830 SS=F	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements, except a facility with a licensed resident capacity of six or fewer is exempt from rental licensing regulations imposed by any town, municipality, or county. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	0 830		

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	28438	A. BUILDING: _____ B. WING _____	10/22/2025

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0 830	Continued From page 27 review, the licensee failed to follow applicable state and local laws, regulations, standards, ordinances, and codes related to smoking for five of five residents (R1, R5 R8, R9, R10). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On October 20, 2025, at 11:45 a.m., during the facility tour with registered nurse (RN)-I, the surveyor observed the outside of the facility to have a wooden deck with chairs, and a metal tall butt receptacle for residents to place the finished cigarette butts into. On October 21, 2025, at 12:50 p.m., the surveyor observed the detached garage with assisted living director in residency (ALDIR)-B after hearing residents talk during lunch about smoking in the shed outside. The garage included a broken down cardboard box on the floor with a wooden table placed on top where a resident had been previously working on refinishing it. Three extinguished cigarette butts were on the floor approximately four inches from the cardboard. Two shelves on the right side of the garage included two extinguished cigarette butts within approximately six inches of a aerosol can of starting fluid and a can of wood stain. Below the shelves was a mower, and to the left	0 830		

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0 830	Continued From page 28 of the shelf approximately 18 inches was a gasoline container on the floor. An extinguished cigarette butt was also observed in a plastic container with several rocks in it. However, the butt was not on the rocks. The outside doors of the garage were noted to have a sign that read "STAY OUT STAFF ONLY". Two extinguished cigarette butts were noted on the grass behind the garage. R1 R1's diagnoses included chronic obstructive pulmonary disease (COPD- a chronic lung disease that causes airflow obstruction and makes it hard to breathe) and hypertension (high blood pressure). R1's Assessment dated October 3, 2025, noted R1 "Smokes on the deck outside or in the garage when weather is poor." R1's Service Plan dated October 6, 2025, indicated R1 received services including assistance with bathing and medication administration. R5 R5's diagnoses included bilateral lower extremities deep vein thrombosis. R5's Assessment dated May 30, 2025, noted R5 "Smokes on the deck outside, in garage or in truck." R5's Service Plan dated October 6, 2025, indicated R5 received services including assistance with compression stockings, laundry, and medication administration.	0 830		

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0 830	Continued From page 29 R8 R8's diagnoses included bilateral below knee amputation. R8's Assessment dated August 20, 2025, noted "Smokes in designated smoking area outside." R8's Service Plan dated October 6, 2025, indicated R8 received services including assistance with bathing and medication administration. R9 R9's diagnoses included anemia and congestive heart failure. R9's Assessment dated May 30, 2025, noted "Needs reminders to dispose of cigarette butts in ash can or disposal can." R9's Service Plan dated October 6, 2025, indicated R9 received services including assistance with laundry, housekeeping, and medication administration. R10 R10's diagnoses included artificial left hip joint and bipolar disorder. R10's Service Plan dated October 6, 2025, indicated R10 received services including assistance with bathing, compression stockings, dressing, and medication administration. R10's Assessment dated October 17, 2025, noted "Smokes in designated smoking areas outside." On October 21, 2025, at 12:45 p.m., ALDIR-B	0 830		

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0 830	Continued From page 30 stated she had just learned residents were smoking in the garage and residents were told this is not allowed. The licensee's Resident Smoking policy dated May 25, 2025, noted the following: - "Smoking is permitted only in the designated outdoor smoking area(s) approved by management"; - "Smoking is not permitted inside the building, on balconies, patios attached to private rooms, or within 15 feet of doorways, windows, or air intakes"; and - "The facility maintains compliance with Minnesota fire codes and insurance requirements." The Minnesota Department of Health's Minnesota Clean Indoor Air Act (MCIAA) amendment effective on August 1, 2019, noted smoking was prohibited in health care facilities and clinics. In addition, an indoor area meant a space between a floor and a ceiling that is at least half enclosed by walls, doorways or windows (opened or closed) around the perimeter. A wall included retractable dividers, garage doors, plastic sheeting or any other temporary or permanent physical barrier. Minnesota State Statute 144.414 Prohibitions; Subdivision 3 dated 2022, indicated under a section titled Health care facilities and clinics: (a) Smoking is prohibited in any area of a hospital, health care clinic, doctor's office, licensed residential facility for children, or other health care-related facility, except that a patient or resident in a nursing home, boarding care facility, or licensed residential facility for adults may smoke in a designated separate, enclosed room	0 830		

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0 830	Continued From page 31 maintained in accordance with applicable state and federal laws. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 830		
01290 SS=E	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 (BGS) clearance letter for one of five employees (unlicensed personnel/ULP-D). In addition, the licensee failed to ensure background studies were affiliated with their health facility identification (HFID) for three of four employees	01290		

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01290	Continued From page 32 (ULP-E, housing manager/HM-F, clinical nurse supervisor/CNS-A).This had the potential to affect all residents living within the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on October 20, 2025, at 11:10 a.m., assisted living director in residency (ALDIR)-B stated the licensee was aware of the required contents of an employee records. ULP-D ULP-D was hired on August 8, 2025, to provide direct care services to residents of the facility. ULP-D's employee record included a final registry results for submitted August 5, 2025, but lacked a background study clearance letter. ULP-E ULP-E was hired on August 1, 2022, to provide direct care services to residents of the facility. ULP-E's employee record included a background study clearance letter dated August 17, 2022, submitted through a separate license of an affiliated company.	01290		

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01290	Continued From page 33 HM-F HM-F was hired on June 18, 2025. HM-F's employee record included a background study clearance letter dated June 11, 2025, submitted through a separate license of an affiliated company. CNS-A CNS-A was licensed as a registered nurse effective June 23, 2015. CNS-A was hired on March 6, 2023, to provide direct care services to residents and to provide staff supervision at the facility. CNS-A's employee record included a background study clearance letter dated July 17, 2019, submitted through a separate license of an affiliated company. On October 22, 2025, at 3:05 p.m., ALDIR-B and HM-F stated the background studies had not been affiliated with the licensee's HFID number. In addition, ALDIR-B stated ULP-D had only been working in the kitchen and with housekeeping, but not worked alone or on the floor providing cares. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or	01440		

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01440	Continued From page 34 therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual began working for the licensee for one of one unlicensed personnel (ULP)-H. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	01440		

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01440	Continued From page 35 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-H was hired on August 5, 2025, to provide direct care services to residents. On October 21, 2025, from 7:31 a.m. to 10:02 a.m., the surveyor observed ULP-H administer medications and prepare breakfast for residents at the facility. ULP-H's record lacked documented evidence of a supervision of performing delegated tasks within 30 calendar days. On October 22, 2025, at 1:05 p.m., assisted living director in residency (ALDIR)-B stated a supervision had not been completed as required. The licensee's Supervision of Unlicensed Personnel policy dated April 24, 2023, noted direct supervision of unlicensed personnel providing delegated services must be performed within 30 days after the person begins working for the facility and has been trained and determined competent to perform all the tasks assigned. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01470 SS=D	144G.63 Subd. 2 Content of required orientation	01470		

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01470	Continued From page 36 (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must	01470		

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01470	Continued From page 37 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 the challenges it poses to communication; (2) 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 observation, interview, and record review, the licensee failed to ensure employees received orientation to assisted living requirements and regulations prior to providing services for one of four employees (unlicensed personnel/ULP-H). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	01470		

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01470	Continued From page 38 ULP-H was hired on August 5, 2025, to provide direct care services to residents. On October 21, 2025, from 7:31 a.m. to 10:02 a.m., the surveyor observed ULP-H administer medications and prepare breakfast for residents at the facility. ULP-H's record lacked documented evidence of the following required orientation: - overview of the Assisted Living statutes; - review of the provider's policies and procedures; - reporting maltreatment of vulnerable adults; and - review of the types of Assisted Living services the employee would provide and the provider's scope of license. On October 22, 2025, at 1:05 p.m., assisted living director in residency (ALDIR)-B stated a the above required training had been assigned but not completed for ULP-H. The licensee's Assisted Living & Assisted Living with Dementia Care Orientation - All Staff policy dated April 17, 2023, noted all employees must complete orientation to assisted living facility requirements including an overview of the statutes, introduction and review of the licensee's policies related to the provision of services, maltreatment of vulnerable adults, and the types of services as indicated on the Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) and the provider's scope of licensure. No further information was provided.	01470		

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01470	Continued From page 39 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01500 SS=E	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.	01500		

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01500	Continued From page 40 (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. 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 annual training included all required topics for each 12 months of employment for three of three employees (clinical nurse supervisor/CNS-A, registered nurse/RN-I, unlicensed personnel/ULP-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the	01500		

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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
01500	Continued From page 41 situation has occurred repeatedly; but is not found to be pervasive). The findings include: CNS-A CNS-A was hired on March 30, 2023, to provide direct care services to residents and to provide staff supervision at the facility. CNS-A's employee record lacked documented evidence of the following required annual training: - review of the provider's policies and procedures. On October 22, 2025, at 12:45 p.m., assisted living director in residency (ALDIR)-B stated the licensee did not have a form to document annual policy review and the training had not been provided. RN-I RN-I was hired on March 6, 2023, to provide direct care services to residents and to provide staff supervision at the facility. RN-I's employee record lacked documented evidence of the following required annual training: - reporting maltreatment of vulnerable adults; - Assisted Living Bill of Rights; - infection control techniques; - 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; - review of the provider's policies and	01500		

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	28438	A. BUILDING: _____ B. WING _____	10/22/2025

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01500	Continued From page 42 procedures; and - principles of person-centered planning/service delivery. On October 22, 2025, at 12:51 p.m., ALDIR-B stated a the above required annual training had been assigned but had not been completed by RN-I. ULP-C ULP-C was hired on January 5, 2023, to provide direct care services to residents. ULP-C's employee record lacked documented evidence of the following required annual training: - review of the provider's policies and procedures; and - principles of person-centered planning/service delivery. On October 22, 2025, at 12:58 p.m., ALDIR-B stated the above required annual training had been assigned but had not been completed by ULP-C. The licensee's Assisted Living with Dementia Care Annual Training policy dated April 17, 2023, noted all employees would complete annual training on topics including reporting maltreatment of vulnerable adults under section 626.557, assisted living bill of rights, infection control techniques, effective approaches for problem solving when working with challenging behaviors, review of policies and procedures relating to the provision of assisted living services, and how person-centered planning and service delivery apply to direct support services.	01500		

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01500	Continued From page 43 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01540 SS=E	144G.64 (a) (3) Training in Dementia, Mental Illness, and De- (3) for assisted living facilities with dementia care, direct-care staff must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, the staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure three of four employees (unlicensed personnel/ULP-H, registered nurse/RN-I, ULP-C) received the required amount of mental illness and	01540		

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01540	Continued From page 44 de-escalation training within the required time frame. In addition, the licensee failed to ensure one of four employees (RN-I) received the required amount of dementia care training in the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: The facility held an assisted living with dementia care license effective May 1, 2025. During the entrance conference on October 20, 2025, at 11:10 a.m., assisted living director in residency (ALDIR)-B and registered nurse (RN)-I stated they were aware of the required contents of the employee records. ULP-H ULP-H was hired on August 5, 2025, to provide direct care services to residents. On October 21, 2025, from 7:31 a.m. to 10:02 a.m., the surveyor observed ULP-H administer medications and prepare breakfast for residents at the facility. ULP-H's record lacked documented evidence of the following required training:	01540		

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01540	Continued From page 45 - training in mental illness and de-escalation by July 1, 2025. On October 22, 2025, at 1:05 p.m., ALDIR-B stated the training had been assigned, but ULP-H had not completed it as required. RN-I RN-I was hired on March 6, 2023, to provide direct care services to residents and to provide staff supervision at the facility. RN-I's record lacked evidence of the following required training: - training in mental illness and de-escalation by July 1, 2025; and - two hours annual dementia care training. On October 22, 2025, at 12:51 p.m., ALDIR-B stated a the above required training had been assigned but not been completed by RN-I. ULP-C ULP-C was hired on January 5, 2023, to provide direct care services to residents. ULP-C's employee record lacked documented evidence of the following required training: - training in mental illness and de-escalation by July 1, 2025. On October 22, 2025, at 12:58 p.m., ALDIR-B stated the above required training had been assigned but not been completed by ULP-C. The licensee's Assisted Living with Dementia Care: Dementia Training policy dated April 17, 2023, noted supervisors and direct-care staff would complete a minimum of two hours training	01540		

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01540	Continued From page 46 on topics related to dementia care for each 12 months of employment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01540		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (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	01620		

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01620	Continued From page 47 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 interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment no more than 90 days after the last assessment for one of two residents (R2) with records reviewed. 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	01620		

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01620	Continued From page 48 situation has occurred only occasionally). The findings include: R2's diagnoses included hypertension (high blood pressure). R2's Service Plan dated October 6, 2025, indicated R2 received services including assistance with bathing, toileting, and medication administration. R2's record contained assessments as follows: - Assessment dated January 8, 2025; - Assessment dated April 15, 2025 (seven days over 90 days); and - Assessment dated July 21, 2025; (90 days due on October 19, 2025). On October 22, 2025, at 9:57 a.m., RN-I stated the assessments for R2 were greater than 90 days apart and had not been completed timely. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01650 SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring	01650		

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01650	Continued From page 49 assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. 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 the required content for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	01650		

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01650	Continued From page 50 R1's diagnoses included chronic obstructive pulmonary disease (COPD- a chronic lung disease that causes airflow obstruction and makes it hard to breathe) and hypertension (high blood pressure). On October 21, 2025, at 3:05 p.m., the surveyor observed R1 in his room, sitting in a chair, watching television. R1's Service Plan dated October 6, 2025, indicated R1 received services including assistance with bathing and medication administration. However, it lacked a contingency plan including: - information as to who has authority to sign for the resident in an emergency. On October 22, 2025, at 9:30 a.m., registered nurse (RN)-I stated the required information was not included on the service plan for R1. The licensee's Contents of Service Plans policy dated April 17, 2023, noted the service plan would include a contingency plan including information on who has authority to sign for the resident in an emergency. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01690 SS=F	144G.71 Subdivision 1 Medication management services (a) This section applies only to assisted living facilities that provide medication management	01690		

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01690	Continued From page 51 services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and maintain current written medication management policies and procedures under the supervision and direction of a registered nurse (RN).	01690		

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01690	Continued From page 52 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on October 20, 2025, at 11:10 a.m., assisted living director in residency (ALDIR)-B and RN-I stated the licensee provided medication management services to the licensee's residents. The licensee's provided policies lacked: - monitoring and evaluation of medication use; and - resolving medication errors. On October 22, 2025, at 10:25 a.m., ALDIR-B stated they would provide the requested policies. However, the above policies were not received. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01690		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the	01890		

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01890	Continued From page 53 expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to date time-sensitive medications with an open date for one of ten residents (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on October 20, 2025, at 11:10 a.m., assisted living director in residency (ALDIR)-B and registered nurse (RN)-I stated the licensee provided medication management services to the licensee's residents. On October 22, 2025, at 8:35 a.m., the surveyor observed the licensee's medication cart with unlicensed personnel (ULP)-H and noted the following: - R4's Ventolin HFA 90 microgram (mcg) inhaler lacked a date when opened; and - R4's Trelegy Ellipta lacked a date when opened. At this time, ULP-H stated all time-sensitive medications should be dated when opened.	01890		

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01890	Continued From page 54 On October 22, 2025, at 9:22 a.m., RN-I stated staff are expected to date all time-sensitive medications when opened. The manufacturer's instructions for use for Ventolin HFA dated December 2014, noted the inhaler should be thrown away 12 months after the foil pouch is opened. The manufacturer's instructions for use for Trelegy Ellipta inhaler dated January 2019, noted to throw the inhaler 6 weeks after opened. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for one of one resident (R2) with hospital-style bed rails. 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	02310		

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02310	Continued From page 55 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: R2's diagnoses included hypertension (high blood pressure). R2's Assessment dated July 21, 2025, noted R2 was independent with bed mobility, has decreased strength related to a stroke, and has a hospital bed with bilateral quarter rails to promote independence with bed mobility. It noted the area for zone one (the area within the rails) was less than 4 3/4 inches, zone two (the area under the rail, between rail supports or next to a single rail support) was less than 4 3/4 inches, zone three (the area between the rail and mattress) was less than 4 3/4 inches, and zone four (the area under the rail, at the ends of the rail) was less than 2 3/8 inches. However, it lacked the actual measurements of the zones. R2's Service Plan dated October 6, 2025, indicated R2 received services including assistance with bathing, brace, toileting, and medication administration. On October 22, 2025, at 10:57 a.m., the surveyor observed registered nurse (RN)-I measure R2's bed rail on the left side of R2's bed. Zone one measured between 2 to 3 1/8 inches. Zone 2 measured 0 inches, zone three measured 2 inches, and zone four measured 0 inches. At this time, R2 stated she did not have a bed rail on the	02310		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING	540 EAST ISLE STREET ISLE, MN 56342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 56 left side of her bed. Also, RN-I stated the assessment lacked the actual measurements of the bed rail. The licensee's Devices and Device Assessment policy lacked information related to the measurements of the bed rails. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) indicated, "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 without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28438	A. BUILDING: _____ B. WING _____	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING	540 EAST ISLE STREET ISLE, MN 56342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 57 interventions to mitigate safety risk or negotiated risk agreements". Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. The FDA, "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients." The FDA also identified, "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

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

Food & Beverage Inspection Report

Establishment Info

VITACARE LIVING
540 EAST ISLE STREET
Isle, MN 56342
Mille Lacs County
Parcel:

Phone:

License Info

License: HFID 28438

Risk:
License:
Expires on:
CFPM: Tyler Gage Beacham
CFPM #: CFPM 56750; Exp: 1/20/2028

Inspection Info

Report Number: F1017251176
Inspection Type: Full - Single
Date: 10/20/2025 Time: 11:48:53 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 1
Delivery: Emailed

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control
6-501.12A *Priority Level: Priority 3 CFP#: 55*
MN Rule 4626.1520A Clean and maintain all physical facilities clean.
COMMENT: Pantry located upstairs was observed with food debris on the floor, clean the pantry to be free of food debris.
Comply By: 10/20/2025 Originally Issued On: 10/20/2025

Food & Beverage General Comment

Discussion

Avoid bare hand contact with ready to eat food, hand washing, employee illness log.

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 F1017251176 from 10/20/2025

Tyler Gage Beacham
Food Manager

Nate Topp,
Public Health Sanitarian 2
320-223-7333
nate.topp@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

VITACARE LIVING
Isle
County/Group: Mille Lacs County

Inspection Info

Report Number: F1017251176
Inspection Type: Full
Date: 10/20/2025
Time: 11:48:53 AM

Food Temperature: Product/Item/Unit: Swedish Meatballs**; Temperature Process:** Hot-Holding
Location: Warmer at 150 Degrees F.
Comment:
Violation Issued?: No

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

Food Temperature: Product/Item/Unit: Milk**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 40 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

VITACARE LIVING
Isle
County/Group: Mille Lacs County

Inspection Info

Report Number: F1017251176
Inspection Type: Full
Date: 10/20/2025
Time: 11:48:53 AM

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

Minnesota (MDH) Version
EH Manager; RPT: F1017251176

Food Establishment Inspection Report

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

No. of Risk Factor/Intervention/Violations	0	Date: 10/20/2025
No. of Repeat Risk Factor/Intervention/Violations		Time: 11:48:53 AM
Score (optional)		Dur: min

Establishment:	Address:	City/State:	Zip:	Phone:
VITACARE LIVING	540 EAST ISLE STREET	Isle, MN	56342	
License/Permit #:	**Permit Holder:**	**Purpose of Inspection:**	**Est. Type:**	**Risk Category:**
HFID 28438		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	N/A	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	N/O	Proper eating, tasting, drinking, tobacco use		
7	N/O	No discharge from eyes, nose, and mouth		
	Preventing Contamination by Hands			
8	N/O	Hands clean and properly washed		
9	N/O	No bare hand contact with RTE foods, alternatives		
10	IN	Adequate handwashing sinks supplied and access		
	Approved Source			
11	IN	Food obtained from approved source		
12	N/O	Food Received at proper temperature		
13	IN	Food in good condition, safe & unadulterated		
14	N/O	Records available: shellstock tags, parasite dest.		
	Protection From Contamination			
15	N/O	Food separated and protected		
16	IN	Food-contact surfaces; cleaned & sanitized		
17	IN	Proper Disposition of returned, previously served, reconditioned,& unsafe food		

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

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

GOOD RETAIL PRACTICES

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

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

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

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

Follow-up: Follow-up Date: