Electronically Delivered

January 15, 2026

Licensee
Ageless Care Incorporated
702 7th Street Southwest
Roseau, MN 56751

RE: Project Number(s) SL30550016

Dear Licensee:

On December 23, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on August 8, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

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Electronically Delivered

September 24, 2025

Licensee
Ageless Care Incorporated
702 7th Street Southwest
Roseau, MN 56751

RE: Project Number(s) SL30550016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 8, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

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

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

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

The correction order documentation should include the following:

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

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

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

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Jessie Chenze

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30550	A. BUILDING: _____ B. WING _____	08/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGELESS CARE INCORPORATED	702 7TH STREET SW ROSEAU, MN 56751

(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: SL30550016-0 On August 4, 2025, through August 8, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 23 residents; 23 receiving services under the Assisted Living Facility license. An immediate correction order was identified on August 5, 2025, issued for SL30550016-0, tag identification 1290. The correction order for tag identification 1290 contains updated language in the scope and severity level statement at the beginning of the order, reflecting changes that went into effect July 1, 2025.	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.	

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0 480	Continued From page 1	0 480		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food 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;	0 480		

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0 480	Continued From page 2 (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated, August, 6, 2025, for the specific	0 480		

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0 480	Continued From page 3 Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure infection control standards were followed for one of two employees (unlicensed personnel (ULP)-D) during medication administration. In addition, the licensee failed to ensure infection control standards were followed to disinfect shared reusable resident equipment for one of one employee (ULP)-D. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	0 510		

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0 510	Continued From page 4 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 August 4, 2025, at 1:15 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A was identified as responsible for the licensee's infection control program. On August 5, 2025, at 8:12 a.m., the surveyor observed ULP-D prepare and administer R2's Humalog (rapid-acting) and Lantus (long-acting) insulins, monitor R2's blood pressure with a shared automatic blood pressure machine and administer R2's medications. Without performing hand hygiene, ULP-D exited R2's room with the blood pressure machine and put the blood pressure machine in the laundry room on the shelf, without disinfecting the blood pressure machine. In addition, the surveyor did not observe any disinfecting wipes or solution to clean the blood pressure machine after use. At 8:32 a.m., ULP-D proceeded and entered R5's room and without performing hand hygiene, ULP-D prepared and administered R5's medications, handed R5 nasal spray to self-administer. ULP-D washed hands and exited R5's room. Immediately following the observations, ULP-D stated she should have performed hand hygiene after administering R2's medications and disinfected the shared blood pressure machine. On August 6, 2025, at 12:40 p.m., licensed	0 510		

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0 510	Continued From page 5 practical nurse (LPN)-G stated staff should be disinfecting the blood pressure machine after each use and perform hand hygiene in between administering resident medications. Registered nurse (RN)-E stated he was unsure of the licensee's policy on disinfecting equipment; however, stated staff should be washing hands before and after administering medications. The licensee's Infection Control policy dated June 12, 2015, indicated equipment used for client care would be properly cleaned and hands should be washed before assisting with medications and before and after treatments. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance	0 650		

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0 650	Continued From page 6 reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records contained the required content for two of two employees (unlicensed personnel (ULP)-F, ULP-I.) This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 August 4, 2025, at 1:15 p.m., office manage (OM)-C and registered nurse (RN)-E stated licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A was responsible for maintaining employee records and LALD/CNS-A was currently was out of the country. ULP-F was hired June 17, 2024, and ULP-I was hired March 28, 2025, to provide direct care	0 650		

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0 650	Continued From page 7 services to the licensee's residents. On August 5, 2025, at 9:08 a.m., the surveyor observed ULP-F assist R3 with straight catheterization procedure (technique used to insert a catheter into the bladder to drain urine). Immediately following the procedure, ULP-F stated she was trained in person by licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A in the straight catheterization procedure. R3's July and August 2025 Service Recap Summary indicated R3 was scheduled and received straight catheterization procedure twice a day. ULP-F's and ULP-I's employee records lacked evidence ULP-F and ULP-I had been trained and demonstrated competency by the RN in straight catheterization procedure. In addition, ULP-F's employee record lacked evidence ULP-F was trained and deemed competent on preparing medications for planned and unplanned resident time away. On August 6, 2025, at 1:30 p.m., RN-E and OM-C stated they were unable to find documentation staff were trained and demonstrated competencies to LALD/CNS-A in R3's straight catheterization procedure. OM-C stated before LALD/CNS-A went on vacation, all paperwork had been filed so all employee documents should be in the employee's record. RN-E stated they would attempt to contact LALD/CNS-A to inquire about missing training records noted above and would send any additional documents to the surveyor via email no later than the end of the day August 7, 2025.	0 650		

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0 650	Continued From page 8 On August 8, 2025, at 8:00 a.m., the surveyor had not received any additional documents via email from the licensee. The licensee's Staff Competency policy dated September 7, 2023, indicated unlicensed personnel performing delegated tasks in an assisted living facility must has successfully complete training and demonstrated competency by successfully completing a written or oral test on all delegated tasks they will perform. The licensee's Personnel Records policy dated June 12, 2015, indicated at a minimum, the following documents were kept in the personnel record, as applicable to job requirements: -records of annual training and infection control; and -competency evaluations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the requirements of the Minnesota State Fire Code. This had the potential to directly affect all residents, staff, and	0 775		

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0 775	Continued From page 9 visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: On a facility tour on August 5, 2025, from 9:45 a.m. to 11:25 a.m., with office manager (OM)-C, the following observations were made of non-compliance with the requirements of the Minnesota State Fire Code (MSFC) in Minnesota Rules Chapter 7511: FIRE-RESISTANT RATED DOORS The door leading from the corridor to the laundry room was not identified with a tag indicating a fire-resistant rating and was not provided with a self-closing device. The door and frame had a different appearance from all other doors in the facility. All other doors in the facility including utility rooms, mechanical rooms, storage rooms, and resident rooms were fire resistant rated doors with self-closing devices to automatically close and latch the doors. During the tour OM-C, stated the laundry room door was replaced. It was explained that all doors in the fire-resistant rated walls of the corridor when replaced are required to be maintained as designed and	0 775		

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0 775	Continued From page 10 installed at the time of construction approval. FIRE-RESISTANT RATED DOOR CLOSERS The doors leading into the resident rooms from the corridor were provided with self-closing spring hinges that did not have spring tension to automatically close the doors to prevent the spread of smoke and fire into the exit path corridor. It was explained that fire-resistant rated doors are required to be maintained with self-closing devices as designed and installed at the time of construction approval. FIRE ALARM SYSTEM MAINTENANCE During the tour the annual documentation was requested indicating the fire alarm system was tested annually as required. On August 7, 2025, at 4:00 p.m., an email was received with documentation of fire sprinkler system five year required maintenance. The email did not include documentation of annual fire alarm system testing. FIRE SPRINKLER SYSTEM MAINTENANCE During the tour the fire sprinkler annual maintenance documentation was reviewed indicating the system was due for a 20-year sprinkler head inspection. During the tour documentation was requested indicating the 20-year sprinkler head inspection was completed.	0 775		

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0 775	Continued From page 11 On August 7, 2025, at 4:00 p.m., an email was received including an accepted proposal dated August 7, 2025, to complete the 20-year sprinkler head inspection. No further information was provided. ILLUMINATED EXIT SIGNS During the tour it was observed the exit signs did not have a test button to verify emergency back up power was supplied to the exit lights. It was explained that emergency exit lights are required to be illuminated with a backup power source in order for occupants to navigate to an exit in the event of an emergency with a power outage. OXYGEN STORAGE There was a portable oxygen cylinder in resident sleeping room 17 not stored in a rack to maintain the cylinder in the upright position. It was explained that oxygen cylinders are required to be stored in a rack while not in use to maintain the cylinder in the upright position. MECHANICAL EQUIPMENT ROOM STORAGE Both rooms identified on the corridor side of the door as Utility Room contained storage around and limiting access to fire sprinkler, mechanical and electrical equipment. It was explained all fire sprinkler, mechanical and electrical equipment shall be maintained with clear space for maintenance access and access	0 775		

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0 775	Continued From page 12 by responders in the event of an emergency. ELECTRICAL DEVICE/ FIXTURE COVERS There was a cover missing on the electrical box exposing electrical wires on the boiler in the Utility Room across the corridor from the Utility Room with the fire sprinkler riser in it. The light fixture globe cover was missing in the living room of resident sleeping room 13. It was explained that all electrical connection covers and light fixture covers are required to be maintained as designed and installed according to manufactures instructions. During the facility tour OM-C, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique	0 810		

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0 810	Continued From page 13 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 required content, make the plan readily available, provide required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of	0 810		

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0 810	Continued From page 14 the residents). The findings include: During observation on August 5, 2025, at 9:20 a.m., the surveyor observed the fire safety and evacuation plan was not located in a central location accessible to all staff and occupants. The plan was located in the main office which is at times locked, and the plan location was not identified in a conspicuous location accessible to all building occupants. On August 5, 2025, at 9:25 a.m., office manager (OM)-C, provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. On August 7, 2025, at 4:00 p.m., additional documentation was received by email. FIRE SAFETY AND EVACUATION PLAN The licensee provided FSEP, failed to include the following: The location and number of resident sleeping rooms were not identified on the posted FSEP evacuation floor plan posted near the front main door. There was floor plans posted at the end of two of the corridors near the exit door with resident room numbers included, FSEP evacuation floor plans were not observed in the other corridors or common areas. The surveyor explained to OM-C, that resident sleeping room numbers are required to be included on all evacuation floor plans in order to direct building occupants to an exit in the event of a fire or similar emergency.	0 810		

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0 810	Continued From page 15 The available FSEP did not identify specific fire protection actions for residents to take as evident by not providing procedures for residents to take in this specific facility in the event of a fire or similar emergency in writing in the FSEP. The resident actions during a fire or similar emergency are required to provide direction to residents as instruction of how to react on their own if capable, to a fire or similar emergency. On August 7, 2025, at 4:00 p.m., an email was received indicating resident evacuation status but did not include actions specific for residents to take in the event of a fire or similar emergency. During an interview on August 5, 2025, at 9:40 a.m., OM-C, stated resident room numbers were on some of the posted FSEP evacuation floor plans but not all. OM-C, also stated the resident actions to take in the event of a fire or similar emergency would be sent by email. TRAINING Record review of the available documentation indicated the licensee failed to provide training to employees on the FSEP upon hire and at least twice per year as evident by providing documentation fire drills were completed as required but no specific documentation was provided indicating employees completed training based on the FSEP at hire and twice per year thereafter. On August 7, 2025, at 4:00 p.m., an email was received with documentation indicating employees completed fire drills, but no documentation was provided indicating	0 810		

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0 810	Continued From page 16 employees completed FSEP training as required. Record review of the available documentation indicated the licensee failed to provide evacuation training to residents at least once per year as evident by not providing documentation the residents were provided training based on the FSEP at least once annually. During an interview on August 5, 2025, at 9:45 a.m., OM-C, stated training documentation was not available and would send by email. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01290		

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01290	Continued From page 17 review, the licensee failed to obtain a cleared Department of Human Services (DHS) background study, affiliated to the licensee, for one of three employees (unlicensed personnel (ULP)-H). This had the potential to affect all residents living within the facility. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-H was hired on December 29, 2024, to provide direct care services to residents at the facility. On August 4, 2025, at 4:10 p.m., the surveyor observed ULP-H independently completing housekeeping tasks within the building and ULP-H was not under continuous supervision. ULP-H's employee record included a NETstudy 2.0 notification that indicated ULP-H had not been previously determined eligible for employment and must be fingerprinted by November 11, 2024. ULP-H's employee recorded lacked a current cleared background study. The licensee's DHS NETStudy 2.0 employee background study roster, reviewed August 4, 2025, did not include ULP-H, as having an initiated background study associated with the licensee.	01290		

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01290	Continued From page 18 The licensee's Weekly Schedules dated July 28, through August 17, 2025, indicated ULP-H was scheduled to work on the following dates: -July 29, August 4, 12, as a housekeeper; and -August 2, 3, 16, 17, as direct care staff. On August 5, 2025, at 11:43 a.m., office manager (OM)-C confirmed ULP-H was not listed on the NETStudy 2.0 employee roster, and stated this was due to complications obtaining ULP-H's out-of-state birth certificate. On August 5, 2025, at 1:10 p.m., OM-C stated ULP-H was hired to provide direct care to the licensee's residents and had been working as a housekeeper. OM-C stated ULP-H continued to assist with resident cares as needed. OM-C stated ULP-H did not work alone; however, ULP-H was not always under continuous supervision while working. Continuous Direct Supervision defined in NETStudy 2.0 System User Manual Updated July 7, 2023, page 7: Continuous, Direct Supervision - An individual is within sight or hearing of the program's supervising individual to the extent that the program's supervising individual is capable at all times of intervening to protect the health and safety of the persons served by the program. Direct Contact Services - Providing face-to-face care, training, supervision, counseling, consultation, or medication assistance to persons served by the entity. Supervision defined in, NETStudy 2.0 System User Manual Updated July 7, 2023, page 53: Supervision Status Study subjects must be under continuous, direct supervision until the study	01290		

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01290	Continued From page 19 subject is determined eligible of until the entity is notified by DHS that the study subject may provide unsupervised services while the background study is being completed. The supervision status is shown in the "Supervision Required" column for convenience. However, programs are instructed to rely on background study notices for supervision status and other background study determination information. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or 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	01440		

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01440	Continued From page 20 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 had begun working for the licensee for one of one unlicensed personnel (ULP)-F. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-F was hired June 17, 2024, to provide direct care services to residents of the licensee. On August 5, 2025, at 10:20 a.m., the surveyor observed ULP-F administering R4's scheduled medications. ULP-F's employee record included an Employee Performance Review dated October 1, 2024, evaluating performance; however, ULP-F's employee record lacked documentation of a supervision of ULP-F performing a delegated task within 30 calendar days of providing services	01440		

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01440	Continued From page 21 On August 6, 2025, at 3:45 p.m., office manager (OM)-C and registered nurse (RN)-E reviewed ULP-F's employee file and stated they were unable to find documentation of supervision of ULP-F performing a delegated task by an RN. RN-E stated they would try and contact LALD/CNS-A to see if LALD/CNS-A completes a supervision of a delegated task as part of supervising ULPs within 30 days, and if were able to provide would email surveyor documentation. On August 7, 2025, at 4:30 p.m., the surveyor had not received any additional requested documents sent via email by the licensee. The licensee's Supervision-Comprehensive Services policy date June 12, 2015, indicated direct supervision of home health aides performing delegated tasks would be provided within 30 days after the individual begins working for the home care provider and thereafter as needed based on performance. The RN would document supervision in the clinical record and in the employee's, personnel file related to performance management. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another	01500		

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01500	Continued From page 22 source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. 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	01500		

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01500	Continued From page 23 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 observation, interview, and record review, the licensee failed to ensure employees performing direct care services completed the required annual training for one of two employees (registered nurse (RN)-E). This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on August 4, 2025, at 1:15 p.m., office manager (OM)-C and RN-E stated license assisted living director/clinical nurse supervisor (LALD/CNS)-A was responsible for assigning employee training through Educare (web-based training program).	01500		

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01500	Continued From page 24 RN-E stated LALD/CNS-A was currently out of the country and RN-E was filling in until LALD/RN-A returned from vacation. RN-E had a hire date of March 26, 2020, to supervise and provide direct care services to the residents of the facility. RN-E's employee record lacked evidence RN-E successfully completed annual training in 2024 or 2025 as required to include: -reporting maltreatment of vulnerable adults or minors; -assisted Living Bill of Rights; -infection control techniques including tuberculosis; -effective approaches to use to problems 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 provider's policies and procedures; -principles of person-centered planning/service delivery; and -review of provider's policies and procedures. On August 6, 2025, at 3:40 p.m., RN-E stated LALD/CNS-A had assigned RN-E annual training and RN-E had not yet completed. RN-E verified RN-E's last training transcripts were completed in 2023. The licensee's policy on Annual Training was requested and not received. The licensee's Personnel Records policy dated June 12, 2015, indicated at a minimum, the following documents would be kept in the personnel record, as applicable to job	01500		

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01500	Continued From page 25 requirements; -records of annual training and infection control training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01530 SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors 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; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a 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 the initial two hours of training	01530		

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	30550	A. BUILDING: _____ B. WING _____	08/08/2025

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01530	Continued From page 26 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 direct care staff received the required two hours of initial training on mental illness and de-escalation topics for four of four employees (registered nurse (RN)-E, (unlicensed personnel (ULP)-F, ULP-H, ULP-I). This had the potential to affect all residents and staff. 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: RN-E	01530		

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01530	Continued From page 27 RN-E was hired March 26, 2020, to supervise and provide direct care services to the residents of the licensee. During the course of the survey August 4, 2025, through August 6, 2025, the surveyor observed RN-E provide care and services to the residents of the facility. ULP-F ULP-F was hired June 17, 2024, to provide direct care services to the residents of the licensee. On August 5, 2025, at 10:56 a.m., the surveyor observed ULP-F apply R4's compression stocking. ULP-H ULP-H was hired October 29, 2024, to provide direct care services to the residents of the licensee. ULP-I ULP-I was hired March 28, 2025, to provide direct care services to the residents of the licensee. RN-E, ULP-F, ULP-H, and ULP-I's records lacked documentation the required two hours of initial training on mental illness and de-escalation topics were completed which became effective July 1, 2025. On August 6, 2025, at 9:52 a.m., office manager (OM)-C stated licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A was responsible to assigning Educare (web-based training program) training for all employees. OM-C stated only newly hired staff	01530		

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01530	Continued From page 28 have been assigned training on mental illness and de-escalating and not for all staff. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
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 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.	01650		

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01650	Continued From page 29 This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure the service plan was revised to reflect the current services provided for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on August 4, 2025, at 1:15 p.m., registered nurse (RN)-E stated licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A was the primary person responsible for maintaining resident services plans and RN-E would assist as needed. RN-E stated he worked for the licensee every other month and filled in when LALD/CNS-A took time off. R2's diagnoses included diabetes type II. R2's Individualized Treatment and Therapy Plan dated January 9, 2024, directed to monitor R2's blood glucose three times a day. R2's Service Plan dated July 8, 2025, included monthly blood glucose supervision by RN; however, did not include R2 received blood	01650		

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01650	Continued From page 30 glucose monitoring three times a day. R2's August 2025 Treatment Recap Summary, indicated R2 was scheduled and received blood glucose monitoring three times a day. On August 6, 2025, at 3:40 p.m., office manager (OM)-C stated R2 received blood glucose monitoring and verified R2's Service Plan dated July 8, 2025, did not include blood glucose monitoring three times a day. OM-C stated LALD/CNS-A had completed an addendum to R2's service plan and printed a new service plan dated effective August 6, 2025, and stated they would have R2 sign a new service plan that included blood glucose monitoring three times a day. The licensee's policy on service plans was requested and not received. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure refrigerated medications were maintained at manufacturer's	01880		

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01880	Continued From page 31 recommended temperatures by failing to monitor and document resident's personal medication refrigerator temperatures. 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 August 4, 2025, at 1:15 p.m., registered nurse (RN)-E stated medications were securely stored in each resident's room including medications that required refrigeration storage. R2's Individualized Medication Management Plan dated July 11, 2025, indicated R2 required medication storage and R2's medications were stored in R2's room and R2's insulin was stored in R2's refrigerator. R2's Service Plan dated July 8, 2025, indicated R2's medications were stored in R2's room and R2 required medication administration assistance. On August 6, 2025, at 11:25 a.m., the surveyor reviewed R2's personal refrigerator with ULP-D. R2's refrigerator lacked a thermometer to record temperatures and the following medications were observed being stored in R2's refrigerator: -seven unopened Humalog Kwikpen (fast-acting)	01880		

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01880	Continued From page 32 prefilled insulin pens; and -four unopened Lantus SoloStar (long-acting) prefilled insulin pens. ULP-D stated resident refrigerator temperatures were not being monitored for those residents that stored medications in their personal refrigerators. The manufacture's instructions for Lantus SoloStar insulin dated June 2022, indicated Lantus unopened insulin should be stored at 36 to 46 degrees Fahrenheit (F). The manufacture's instruction for Humalog Kwikpen insulin dated July 2023, indicated unopened Humalog insulin should be stored at 36 to 46 degrees F. The licensee's Storage of Client's Personal Medication policy dated September 23, 2019, indicated when the licensee was providing medication management all personal medications would be stored in the client's private living space in accordance to the manufacturer's directions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to	01950		

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01950	Continued From page 33 the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record for one of two residents (R3) who received treatment and therapy services. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on August 4, 2025, at 1:15 p.m., office manager (OM)-C and RN-E stated the licensee provided treatment and	01950		

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01950	Continued From page 34 therapy services to residents at the facility. R3's diagnoses included malignant neoplasm of the bladder, retention of urine, Alzheimer's disease and dementia. R3's Service Plan dated April 15, 2025, indicated R3 received assistance with straight catheterization (technique used to insert a catheter into the bladder to drain urine) twice a day. On August 5, 2025, at 9:08 a.m., the surveyor observed unlicensed personnel (ULP)-F put on a pair of gloves, gather iodine swab, catheter tube, lubricant, graduate, and disposable pad. R3 was in supine position on the couch, ULP-E cleansed R3's urethra, removed the catheter from the package, applied lubricant to the tip of the catheter and inserted the catheter into R3's urethra advancing slowly until urine started to flow from the catheter into the graduate. Once urine stopped flowing, ULP-E removed the catheter, emptied the graduate of urine into the toilet, threw the used supplies into the garbage, removed gloves and washed hands. ULP-F documented procedure completed in R3's record. ULP-F stated licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A trained ULP-F on straight catheterization procedure. ULP-F stated there were no written instructions in R3's record on the procedure for straight catheterization. ULP-F reviewed the license's policy and procedure book in the nurses office and was unable to find a written procedure on straight catheterization. R3's July and August 2025 Treatment Recap Summary indicated R3 was scheduled and	01950		

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01950	Continued From page 35 received straight catheterization twice a day. R3's Individualized Treatment and Therapy Plan dated January 22, 2025, included straight catheterization twice daily and to notify the nurse if urine output is less than 300 milliliters (ml). R3's record lacked written instructions on the procedure in straight catheterization. On August 6, 2025, at 1:30 p.m., OM-C and RN-E stated they were unable to find written instructions for straight catheterization and LALD/CNS-A completed all of staff training. RN-E stated they would attempt to contact LALD/CNS-A and inquire if LALD/CNS-A prepared written instructions for R3's straight catheterization and send to surveyor via email. On August 8, 2025, at 8:00 a.m., the surveyor had not received any further documentation from the licensee. The licensee's Treatment and Therapy Management policy dated June 12, 2015, indicated the RN would provide education to the client/responsible party and instruct other team members based on written instructions prepared by the RN. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an	01960		

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01960	Continued From page 36 assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a resident treatment plan was followed and any follow up procedure was provided to meet the resident's needs for one of one resident (R2) who received daily blood pressure monitoring. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on August 4, 2025, at 1:15 p.m., office manager (OM)-C and registered nurse (RN)-E stated the licensee provided treatment and therapy services. R2's diagnosis included hypertension (high blood pressure) and chronic kidney disease.	01960		

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01960	Continued From page 37 R2's Individualized Treatment and Therapy Plan dated May 17, 2024, included checking R2's blood pressure daily and contact the RN if systolic (top number) is less than 90 or greater than 180 or diastolic (bottom number) is less than 50 or greater than 90. R2's Service Plan dated July 8, 2025, included blood pressure monitoring daily and contact RN if systolic (top number) is less than 90 or greater than 180 or diastolic (bottom number) is less than 50 or greater than 90. On August 5, 2025, at 8:12 a.m., the surveyor observed unlicensed personnel (ULP)-D monitor R2's blood pressure with an automatic blood pressure machine with blood pressure results of 146/95 millimeters of mercury (mm/Hg). R2's vital signs report dated July 1, 2025, to August 5, 2025, indicated R2's recorded blood pressures were out of parameters and lacked documentation the RN was notified or any any follow up procedure was provided on the following dates: -July 10, 2025, R2's blood pressure was recorded at 145/113; -July 12, 2025, R2's blood pressure was recorded at 132/104; -July 14, 2025, R2's blood pressure was recorded at 161/91; -July 17, 2025, R2's blood pressure was recorded at 143/105; -July 18, 2025, R2's blood pressure was recorded at 135/94; -July 24, 2025, R2's blood pressure was recorded at 139/102; -July 25, 2025, R2's blood pressure was	01960		

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01960	Continued From page 38 recorded at 132/106; -July 26, 2025, R2's blood pressure was recorded at 143/110; -July 27, 2025, R2's blood pressure was recorded at 158/102; -July 28, 2025, R2's blood pressure was recorded at 170/148; -July 30, 2025, R2's blood pressure was recorded at 135/97; -July 31, 2025, R2's blood pressure was recorded at 145/94; -August 3, 2025, R2's blood pressure was recorded at 137/95; -August 4, 2025, R2's blood pressure was recorded at 130/96; and -August 5, 2025, R2's blood pressure was recorded at 146/95. R2's Progress Notes from February 1, 2025, through April 28, 2025, lacked documentation the registered nurse (RN) had been notified of the above noted out of range blood glucose readings; furthermore, R2's record lacked documentation any follow up treatment or procedure was provided. On August 6, 2025, at 1:13 p.m., OM-C and RN-E reviewed R2's record and were unable to find documentation the RN was notified of R2's increased blood pressures as directed. RN-E stated ULP-D did not report R2's blood pressure reading on August 5 of 146/95 mm/Hg. The licensee's Treatment and Therapy Management policy dated June 12, 2015, indicated when a treatment or therapy was not administered as ordered or prescribed, staff would document the reason why it was not administered and any follow up procedures	01960		

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01960	Continued From page 39 provided to meet the client's needs. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure current written or electronically recorded prescriptions were obtained for one of two residents (R2) who received treatment services. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30550	A. BUILDING: _____ B. WING _____	08/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGELESS CARE INCORPORATED	702 7TH STREET SW ROSEAU, MN 56751

(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
01970	Continued From page 40 R2's diagnoses included diabetes type II. R2's prescriber orders dated June 9, 2025, included blood glucose monitoring four times a day with the FreeStyle Libre monitor (continuous blood glucose monitoring system). R2's Individualized Treatment and Therapy Plan dated January 9, 2024, directed to monitor R2's blood glucose three times a day. R2's Service Plan dated July 8, 2025, included monthly blood glucose supervision by registered nurse (RN); however, lacked R2 received blood glucose monitoring three times a day. R2's August 2025 Treatment Recap Summary, indicated R2 was scheduled and received blood glucose monitoring three times a day. On August 6, 2025, at 12:40 p.m., licensed practical nurse (LPN)-G stated R2 had the FreeStyle Libre and staff were to monitor and record R2's blood glucose three times a day. LPN-G reviewed R2's prescriber orders dated June 9, 2025, that indicated R2's blood glucose was to be monitored four times a day. RN-E reviewed R2's record and stated licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A changed R2's blood glucose monitoring from four times a day to three times a day on June 18, 2025; however, was unable to provide prescriber orders to reflect blood glucose monitoring was decreased to three times a day. The licensee's Treatment and Therapy Management policy dated June 12, 2015, indicated the RN would obtain orders or prescriptions for all treatment and therapies.	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30550	A. BUILDING: _____ B. WING _____	08/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGELESS CARE INCORPORATED	702 7TH STREET SW ROSEAU, MN 56751

(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
01970	Continued From page 41 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		

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

Food & Beverage Inspection Report

Establishment Info

AGELESS CARE INCORPORATED
702 7TH STREET SW
Roseau, MN 56751
Roseau County
Parcel:

Phone:

License Info

License: HFID 30550

Risk:
License:
Expires on:
CFPM:
CFPM #: ; Exp:

Inspection Info

Report Number: F1002251042
Inspection Type: Full - Joint
Date: 8/6/2025 Time: 10:45 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 2
Total Priority 2 Orders: 1
Total Priority 3 Orders: 1
Delivery: Emailed

! **New Order: 3-300B Protection from Contamination: cross-contamination, eggs**
3-302.11A(1) *Priority Level: Priority 1 CFP#: 15*
MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.
COMMENT: AT TIME OF INSPECTION, A RED SUBSTANCE BELIEVED TO BE BLOOD FROM A PACKAGE OF BEEF WAS FOUND TO HAVE LEAKED INTO THE DRAWER OF THE REFRIGERATOR. THE DRAWER CONTAINED PACKETS OF BUTTER IN A ZIPLOC BAG. THE LEAK WAS CLEANED UP AND THE AFFECTED AREA IN THE REFRIGERATOR WAS CLEANED AND SANITIZED. DISCUSSED STORAGE OF RAW MEAT AND EGGS TO PREVENT RISK OF CROSS CONTAMINATION.
Comply By: Complied On Site *Originally Issued On: 8/6/2025*

New Order: 3-300C Protection from Contamination: equipment/utensils, consumers
3-305.11A *Priority Level: Priority 3 CFP#: 39*
MN Rule 4626.0300A Store all food in a clean, dry location; where it is not exposed to splash, dust or other contamination; and at least 6 inches above the floor.
COMMENT: A BOX OF POTATOES WAS OBSERVED TO BE STORED ON THE FLOOR IN THE STORAGE ROOM.
Comply By: Complied On Site *Originally Issued On: 8/6/2025*

! **New Order: 3-500B Microbial Control: hot and cold holding**
3-501.16A2 *Priority Level: Priority 1 CFP#: 22*
MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.
COMMENT: ORANGE JUICE IN A NON-MECHANICALLY COOLED DISPENSER WAS MEASURED TO BE 46 DEGREES F AT TIME OF INSPECTION. STAFF INDICATED THAT THE NIGHT WORKER FILLS THE DISPENSER AT 7 AM. STAFF WERE INSTRUCTED TO DISCARD THE REMAINING ORANGE JUICE AND DISCONTINUE THIS PRACTICE UNTIL ISSUE IS RESOLVED VIA ONE OF THE OPTIONS BELOW:

USE A MECHANICALLY COOLED DISPENSER THAT MAINTAINS COLD HOLDING TEMP OF 41 dF OR BELOW
OR
USE TIME AS PUBLIC HEALTH CONTROL (TPHC). CONTACT INSPECTOR TO DISCUSS DETAILS PRIOR TO IMPLEMENTING A TPHC POLICY AT THIS ESTABLISHMENT.
Comply By: 8/6/2025 *Originally Issued On: 8/6/2025*

New Order: 4-300 Equipment Numbers and Capacities
4-302.14 *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.
COMMENT: NO TEST KIT AVAILABLE TO MEASURE THE QUATERNARY AMMONIA (QA) CONCENTRATION OF THE SANITIZER SPRAY BOTTLE. STAFF PRESENTED CHLORINE TEST STRIPS BUT WERE UTILIZING QA SANITIZER. PROVIDE THE CORRECT TEST STRIPS FOR TYPE OF SANITIZER USED.
Comply By: 8/14/2025 Originally Issued On: 8/6/2025

Food & Beverage General Comment

Note:
This establishment is allowed to prepare and serve food for limited hot holding and immediate service. Any leftover hot items may not be cooled/saved for later service. If leftovers are being saved for the staff, store them in a staff only refrigerator that is labeled as such.

Discussion:
Handwashing
Employee illness
Safe cleaning and sanitizing
Thermometer calibration
Time as public health control (TPHC)

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

I acknowledge receipt of the Bemidji District Office inspection report number F1002251042 from 8/6/2025

Cassandra Hua

Shawny-Ann Elk-Prevost
Operator/CFPM

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

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

Temperature Observations/Recordings

Establishment Info

AGELESS CARE INCORPORATED
Roseau
County/Group: Roseau County

Inspection Info

Report Number: F1002251042
Inspection Type: Full
Date: 8/6/2025
Time: 10:45 AM

Food Temperature: Product/Item/Unit: ORANGE JUICE**; Temperature Process:** Cold-Holding
Location: DISPENSER IN SITTING AREA at 46 Degrees F.
Comment: NON-MECHANICALLY COOLED BEVERAGE DISPENSER
Violation Issued?: Yes

Food Temperature: Product/Item/Unit: SOUR CREAM**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 34 Degrees F.
Comment: WHIRLPOOL COOLER IN STORAGE ROOM
Violation Issued?: No

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

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

Food Temperature: Product/Item/Unit: TARTAR SAUCE**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 40 Degrees F.
Comment: WHIRLPOOL IN MAIN KITCHEN
Violation Issued?: No

Food Temperature: Product/Item/Unit: MEAT, GRAVY, BEANS, ETC. **; Temperature Process:** Hot-Holding
Location: ROVSUN WARMER at 165+ Degrees F.
Comment:
Violation Issued?: No

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

Sanitizer Observations/Recordings

Establishment Info

AGELESS CARE INCORPORATED
Roseau
County/Group: Roseau County

Inspection Info

Report Number: F1002251042
Inspection Type: Full
Date: 8/6/2025
Time: 10:45 AM

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

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** Spray Bottle
Location: **Equal To** 200 PPM
Comment:
Violation Issued?: No

Minnesota (MDH) Version
EH Manager; RPT: F1002251042

Food Establishment Inspection Report

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

No. of Risk Factor/Intervention/Violations	2	Date: 8/6/2025
No. of Repeat Risk Factor/Intervention/Violations		Time: 10:45 AM
Score (optional)		Dur: min

Establishment:	Address:	City/State:	Zip:	Phone:
AGELESS CARE INCORPORATED	702 7TH STREET SW	Roseau, MN	56751	
License/Permit #:	**Permit Holder:**	**Purpose of Inspection:**	**Est. Type:**	**Risk Category:**
HFID 30550		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

	Compliance Status		COS	R
	Supervision			
1	IN	Person in charge present, demonstrate knowledge and performs duties		
2	IN	Certified Food Protection Manager		
	Employee Health			
3	IN	knowledge, responsibiities, and reporting		
4	IN	Proper use of restriction and exclusion		
5	IN	Response to vomiting, diarrheal events		
	Good Hygienic Practices			
6	IN	Proper eating, tasting, drinking, tobacco use		
7	IN	No discharge from eyes, nose, and mouth		
	Preventing Contamination by Hands			
8	IN	Hands clean and properly washed		
9	IN	No bare hand contact with RTE foods, alternatives		
10	IN	Adequate handwashing sinks supplied and access		
	Approved Source			
11	IN	Food obtained from approved source		
12	N/O	Food Received at proper temperature		
13	IN	Food in good condition, safe & unadulterated		
14	N/A	Records available: shellstock tags, parasite dest.		
	Protection From Contamination			
15	OUT	Food separated and protected	X	
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/A	Proper cooling time and temperature		
21	IN	Proper hot holding temperatures		
22	OUT	Proper cold holding temperatures		
23	IN	Proper date marking & disposition		
24	N/A	Time as public health control;procedures & record		
	Consumer Advisory			
25	N/A	Consumer advisory provided for raw or undercooked foods		
	Highly Susceptible Populations			
26	IN	Pasteurized foods used; prohibited foods not offered		
	Food/Color Additives and Toxic Substances			
27	N/A	Food additives; approved & properly used		
28	IN	Toxic substances properly identified;stored;used		
	Conformance with Approved Procedures			
29	N/A	Compliance with variance, specialized processes & HACCP plan		

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

GOOD RETAIL PRACTICES

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

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

			COS	R
		Safe Food and Water		
30	IN	Pasteurized eggs used where required		
31		Water & ice from approved source		
32	N/A	Variance obtained for specialized processing methods		
		Food Temperature Control		
33		Proper cooling methods used; adequate equipment for temperature control		
34	N/O	Plant food properly cooked for hot holding		
35	IN	Approved thawing methods used		
36		Thermometers provided & accurate		
		Food Identification		
37		Food properly labeled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present; no unauthorized person		
39	X	Contamination prevented during food prep, storage, & display	X	
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	X	Warewashing facilities: installed, maintained, used; test strips		
49		Non-food contact surfaces clean		
		Physical Facilities		
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities; properly constructed, supplied & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing and plan review		

Person in Charge (signature)

Inspector (signature) Cassandra Hua

Follow-up: Follow-up Date: