

STATE LICENSING COMPLIANCE REPORT

Report #: HL306688091C

Date Concluded: June 27, 2025

Name, Address, and County of Facility

Investigated:

Tamarack Court of Bemidji
1511 Delton Avenue Northwest
Bemidji, MN 56601
Beltrami County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Rhylee Gilb, RN
Special Investigator

The Minnesota Department of Health conducted a complaint investigation to determine compliance with state laws and rules governing the provision of care under Minnesota Statutes, Chapter 144G. The purpose of this complaint investigation was to review if facility policies and practices comply with applicable laws and rules. No maltreatment under Minnesota Statutes, Chapter 626 was alleged.

To view a copy of the correction orders, if any, please visit:

<https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html>, or call 651-201-4201 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached state form.

Minnesota Department of Health

| | | | |
|--|--|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30668 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 06/24/2025 |
|--|--|---|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER TAMARACK COURT OF BEMIDJI | STREET ADDRESS, CITY, STATE, ZIP CODE 1511 DELTON AVENUE NW BEMIDJI, MN 56601 |
|--|---|

| (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 | <p>Initial Comments</p> <p>On June 24, 2025, the Minnesota Department of Health completed a monitoring visit after a natural disaster for project #HL306688091C. No correction orders are issued.</p> | 0 000 | | |

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____