Electronically Delivered

October 20, 2026

Licensee
Bridgeway Estates
103 12th Street Northeast
Little Falls, MN  56345

RE:  Project Number(s) SL30385016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 23, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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**
**St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - 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 $1,500.00**. 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.

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

CLN

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30385 | A. BUILDING: _____ B. WING _____ | 09/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIDGEWAY ESTATES | 103 12TH STREET NE LITTLE FALLS, MN 56345 |

| (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<br><br>*****ATTENTION*****<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.<br><br>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.<br><br>INITIAL COMMENTS:<br><br>SL30385016<br><br>On September 21, 2026, through September 23, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 40 residents; 22 receiving services under the Assisted Living Facility 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 oMinnesota Department of Health is documenting the State Correction Orders using federal software. Tag ut 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.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>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. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30385 | A. BUILDING: _____ B. WING _____ | 09/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIDGEWAY ESTATES | 103 12TH STREET NE LITTLE FALLS, MN 56345 |

| (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 |
|---|---|---|---|---|
| 0 470 | Continued From page 1 | 0 470 | | |
| 0 470 SS=F | 144G.41 Subdivision 1 Minimum requirements<br><br>(11) develop and implement a staffing plan for determining its staffing level that:<br>(i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility;<br>(ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and<br>(iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility;<br>(12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be:<br>(i) awake;<br>(ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time;<br>(iii) capable of communicating with residents;<br>(iv) capable of providing or summoning the appropriate assistance; and<br>(v) capable of following directions;<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to post a daily work schedule at the beginning of each work shift with the required content. This had the potential to affect all residents, staff, and visitors.<br><br>This practice resulted in a level two violation (a | 0 470 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30385 | A. BUILDING: _____ B. WING _____ | 09/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIDGEWAY ESTATES | 103 12TH STREET NE LITTLE FALLS, MN 56345 |

| (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 |
|---|---|---|---|---|
| 0 470 | Continued From page 2<br><br>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).<br><br>The findings include:<br><br>The licensee held an assisted living facility license effective September 1, 2026, and was licensed for a capacity of 50 residents, with a current census of 40 residents.<br><br>During the entrance conference on September 21, 2026, at 9:45 a.m., clinical nurse supervisor (CNS)-A and licensed assisted living director (LALD)-B stated the licensee was familiar with the current minimum assisted living requirements. In addition, they stated they had three shifts as follows:<br>- morning shift (6:00 a.m. to 2:00 p.m.) 1 unlicensed personnel (ULP), and occasionally a second person just to help with lunch;<br>- evening shift (2:00 p.m. to 10:00 p.m.) 1 ULP and (2:00 p.m. to 7:00 p.m.) 1 ULP<br>- night shift (10:00 p.m. to 6:00 a.m.) 1 ULP.<br><br>During the facility tour on September 21, 2026, at 10:15 a.m., with LALD-B, the surveyor observed the daily staff schedule posted inside the main entrance near the staircase. The undated Weekly Schedule noted:<br>- a row with RA/AL marked with a 3 on the evening shift (key identifies this as resident assistant/assisted living and 3 equals shift from 2:00 p.m. to 7:00 p.m.). Please note resident assistant was the licensee's term for ULP; and | 0 470 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30385 | A. BUILDING: _____ B. WING _____ | 09/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIDGEWAY ESTATES | 103 12TH STREET NE LITTLE FALLS, MN 56345 |

| (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 |
|---|---|---|---|---|
| 0 470 | Continued From page 3<br>- a row with RA/AL marked with an X on the day, evening, and night shifts (the key does not identify the meaning of the X).<br><br>On September 23, 2026, at 9:00 a.m., LALD-B stated the posted schedule did not identify the number of ULP working per shift, but stated there was always one ULP, but some days there was an additional ULP. LALD-B stated there was always a person on for the 2:00 p.m. to 7:00 p.m. shift, and if that person calls in, either the day shift person stays or CNS-A or LALD-B work the shift.<br><br>No further information was provided.<br><br>TIME PERIOD OF CORRECTION: Seven (7) days | 0 470 | | |
| 0 510 SS=F | 144G.41 Subd. 3 Infection control program<br><br>(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.<br>(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.<br>(c) The facility must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to establish and | 0 510 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30385 | A. BUILDING: _____ B. WING _____ | 09/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIDGEWAY ESTATES | 103 12TH STREET NE LITTLE FALLS, MN 56345 |

| (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 |
|---|---|---|---|---|
| 0 510 | Continued From page 4<br><br>maintain an infection control program to comply with accepted health care, medical, and nursing standards for infection control for one of two employees (unlicensed personnel/ULP-F). This had the potential to affect all the licensee's residents, staff, and visitors.<br><br>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).<br><br>The findings include:<br><br>On September 22, 2026, at 8:20 a.m., the surveyor observed ULP-F provide perineal cares for R1. R1 called for assistance after having a bowel movement on the toilet. ULP-F performed hand hygiene, placed clean gloves, and assisted R1 to stand and hold onto the motorized scooter in front of the toilet. ULP-F then performed perineal cares to R1's buttocks with wipes, removed the gloves, placed his hands in his pockets to get out the keys, touched the iPad to document the blood glucose reading reported by R1, touched R1's dresser, touched the phone, opened the apartment door, and pushed the cart down the hall. ULP-F then entered R2's door to answer the call, and proceeded to open the medication storage cabinet in the room, placed a glove on his right hand and provided medications for R2 to take on an outing. Upon exiting the room, ULP-F took the trash to the first floor and at this time, performed hand hygiene after removing the glove. | 0 510 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30385 | A. BUILDING: _____ B. WING _____ | 09/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIDGEWAY ESTATES | 103 12TH STREET NE LITTLE FALLS, MN 56345 |

| (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 |
|---|---|---|---|---|
| 0 510 | Continued From page 5<br><br>On September 22, 2026, at 8:40 a.m., ULP-F stated he had not done hand hygiene with the observations above and stated he should have either washed his hands or used sanitizer after assisting R1 in the bathroom, after removing the gloves, and after leaving a resident's room.<br><br>On September 22, 2026, at 12:13 p.m., clinical nurse supervisor (CNS)-A stated staff were expected and trained to perform hand hygiene after removing gloves, after providing perineal cares, and between residents.<br><br>The licensee's Hand Hygiene policy dated March 10, 2026, noted hands must be washed:<br>- before and after direct contact with a resident; and<br>- after removing gloves.<br><br>The Center of Disease Control (CDC) Core Infection Prevention and Control Practices regarding hand hygiene dated November 29, 2022, recommends healthcare personnel should use an alcohol-based rub or wash with soap and water for the following clinical indications: immediately before touching a patient, before performing aseptic task or handling invasive medical devices, before moving from work on a soiled body site to a clean body site on the same patient, after touching a patient or the patient's immediate environment, after contact with blood, body fluids, or contaminated services, and immediately after glove removal.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 510 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30385 | A. BUILDING: _____ B. WING _____ | 09/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIDGEWAY ESTATES | 103 12TH STREET NE LITTLE FALLS, MN 56345 |

| (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 |
|---|---|---|---|---|
| 0 730 | Continued From page 6 | 0 730 | | |
| 0 730 SS=F | 144G.43 Subd. 3 Contents of resident record<br><br>Contents of a resident record include the following for each resident:<br>(1) identifying information, including the resident's name, date of birth, address, and telephone number;<br>(2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative;<br>(3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known;<br>(4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records;<br>(5) the resident's advance directives, if any;<br>(6) copies of any health care directives, guardianships, powers of attorney, or conservatorships;<br>(7) the facility's current and previous assessments and service plans;<br>(8) all records of communications pertinent to the resident's services;<br>(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;<br>(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;<br>(11) documentation that services have been provided as identified in the service plan;<br>(12) documentation that the resident has received | 0 730 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30385 | A. BUILDING: _____ B. WING _____ | 09/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIDGEWAY ESTATES | 103 12TH STREET NE LITTLE FALLS, MN 56345 |

| (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 |
|---|---|---|---|---|
| 0 730 | Continued From page 7<br><br>and reviewed the assisted living bill of rights;<br>(13) documentation of complaints received and any resolution;<br>(14) a discharge summary, including service termination notice and related documentation, when applicable; and<br>(15) other documentation required under this chapter and relevant to the resident's services or status.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to document services provided for five of five residents (R4, R5, R6, R7, R8).<br><br>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).<br><br>The findings include:<br><br>R4<br>R4's diagnoses included atrial fibrillation (a rapid, irregular heartbeat).<br><br>R4's service plan dated August 21, 2026, indicated R4 received assistance with services including activities, music, oldies, and watching tv, game shows.<br><br>R4's Support Plan dated effective August 1, 2026, through July 31, 2027, indicated the licensee was receiving reimbursement for providing R4 | 0 730 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30385 | A. BUILDING: _____ B. WING _____ | 09/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIDGEWAY ESTATES | 103 12TH STREET NE LITTLE FALLS, MN 56345 |

| (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 |
|---|---|---|---|---|
| 0 730 | Continued From page 8<br>assistance with activities and mobility.<br><br>R4's medical record lacked documentation for activities provided and mobility.<br><br>R5<br>R5's diagnoses included hypertension (high blood pressure).<br><br>R5's service plan dated April 9, 2026, indicated R5 received assistance with services including activities assistance including music, oldies, crafts/arts, watching tv, talking or conversing with staff and other residents. Also included activity reminders.<br><br>R5's Support Plan dated effective May 1, 2026, through April 30, 2027, indicated the licensee was receiving reimbursement for providing R5 assistance with socialization.<br><br>R5's medical record lacked documentation for activities provided.<br><br>R6<br>R6's diagnoses included hypertension and macular degeneration (eye disease that damages the macula).<br><br>R6's service plan dated September 21, 2026, indicated R6 received assistance with services including music/listening to records and talking or conversing.<br><br>R6's Support Plan dated effective December 26, 2026, through November 30, 2026, indicated the licensee was receiving reimbursement for providing R6 with socialization.<br><br>R6's medical record lacked documentation for | 0 730 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30385 | A. BUILDING: _____ B. WING _____ | 09/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIDGEWAY ESTATES | 103 12TH STREET NE LITTLE FALLS, MN 56345 |

| (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 |
|---|---|---|---|---|
| 0 730 | Continued From page 9<br>activities provided.<br><br>R7<br>R7's diagnoses included depression and hypertension.<br><br>R7's service plan dated August 21, 2026, indicated R6 received assistance with services including activities including doing chores around the community/house, talking or conversing, trips/shopping, walking/wheeling outdoors, and watching tv.<br><br>R7's Support Plan dated effective March 1, 2026, through February 28, 2027, indicated the licensee was receiving reimbursement for providing R7 with socialization.<br><br>R7's medical record lacked documentation for activities provided.<br><br>R8<br>R8's diagnoses included asthma and anxiety.<br><br>R8's service plan dated July 7, 2026, indicated R7 received services including assistance with activities including cards/crossword puzzles, craft/art including diamond art, and watching tv.<br><br>R8's Support Plan dated effective December 31, 2025, through August 31, 2026, indicated the licensee was receiving reimbursement for providing R8 with socialization.<br><br>R8's medical record lacked documentation for activities provided.<br><br>On September 23, 2026, at 12:49 p.m., clinical nurse supervisor (CNS)-A and licensed assisted living director (LALD)-B stated the licensee does | 0 730 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30385 | A. BUILDING: _____ B. WING _____ | 09/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIDGEWAY ESTATES | 103 12TH STREET NE LITTLE FALLS, MN 56345 |

| (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 |
|---|---|---|---|---|
| 0 730 | Continued From page 10<br>provide socialization for the residents, but do not document the activities provided.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 730 | | |
| 0 775 SS=F | 144G.45 Subd. 2. (a) Fire protection and physical environment<br><br>Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G.<br><br>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).<br><br>The findings include:<br><br>Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated September 23, 2026, for the specific violations related the physical environment under Minnesota | 0 775 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30385 | A. BUILDING: _____ B. WING _____ | 09/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIDGEWAY ESTATES | 103 12TH STREET NE LITTLE FALLS, MN 56345 |

| (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 |
|---|---|---|---|---|
| 0 775 | Continued From page 11<br>Statute 144G.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days. | 0 775 | | |
| 0 810 SS=F | 144G.45 Subd. 2 (b-f) Fire protection and physical environment<br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:<br>(1) location and number of resident sleeping rooms;<br>(2) staff actions to be taken in the event of a fire or similar emergency;<br>(3) fire protection procedures necessary for residents; and<br>(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.<br>(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.<br>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.<br>(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.<br>(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. | 0 810 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30385 | A. BUILDING: _____ B. WING _____ | 09/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIDGEWAY ESTATES | 103 12TH STREET NE LITTLE FALLS, MN 56345 |

| (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 12<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G.<br><br>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).<br><br>The findings include:<br><br>Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated September 23, 2026, for the specific violations related the physical environment under Minnesota Statute 144G.<br><br>TIME PERIOD FOR CORRECTION: Twenty one (21) days. | 0 810 | | |
| 01790 SS=D | 144G.71 Subd. 10 Medication management for residents who will<br><br>(2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for | 01790 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30385 | A. BUILDING: _____ B. WING _____ | 09/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIDGEWAY ESTATES | 103 12TH STREET NE LITTLE FALLS, MN 56345 |

| (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 |
|---|---|---|---|---|
| 01790 | Continued From page 13<br>the length of the anticipated absence, not to exceed seven calendar days;<br>(3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and<br>(4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled.<br>(b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if:<br>(1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and<br>(2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address:<br>(i) the type of container or containers to be used for the medications appropriate to the provider's medication system;<br>(ii) how the container or containers must be labeled;<br>(iii) written information about the medications to be provided;<br>(iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; | 01790 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30385 | A. BUILDING: _____ B. WING _____ | 09/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIDGEWAY ESTATES | 103 12TH STREET NE LITTLE FALLS, MN 56345 |

| (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 |
|---|---|---|---|---|
| 01790 | Continued From page 14<br><br>(v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative;<br>(vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and<br>(vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to provide complete documentation of medications sent with one of one resident (R2) who had an unplanned time away.<br><br>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).<br><br>The findings include:<br><br>During the entrance conference on September 21, 2026, at 10:40 a.m., licensed assisted living director (LALD)-B and clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to 22 of the licensee's | 01790 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30385 | A. BUILDING: _____ B. WING _____ | 09/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIDGEWAY ESTATES | 103 12TH STREET NE LITTLE FALLS, MN 56345 |

| (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 |
|---|---|---|---|---|
| 01790 | Continued From page 15<br>residents.<br><br>On September 23, 2026, at 8:30 a.m., the surveyor observed unlicensed personnel (ULP)-F enter R2's room, and R2 informed ULP-F he planned to go out of the facility and needed his medications. At this time, ULP pulled the prepackaged medications for the 1:00 p.m. dose, opened the prefilled compartment to look at the medications, closed it back up, and handed it to R2.<br><br>On September 23, 2026, at 8:40 a.m., ULP-F stated nothing was sent with R2 for his medications and he did not document in R2's record the medications had been sent with him. ULP-F said he just lets CNS-A and LALD-B know he did it.<br><br>On September 23, 2026, at 12:15 p.m., CNS-A stated when residents leave with their medications, ULP are to document, let her know, and report it to the oncoming shift. CNS-A also stated there is a list to use to send with residents when leaving for several days, but not one medication time, and staff can go into the electronic medication administration record and document the medication was given early and add a note the resident took the medications on an outing.<br><br>The licensee's undated Medications to be Given When Away From Home policy noted:<br>a. Staff will contact the nurse prior to giving medications to the resident or resident representative if there are any questions about what medications can be sent or how to send medications.<br>b. If the RN determines that the original medication containers with proper labels can be | 01790 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30385 | A. BUILDING: _____ B. WING _____ | 09/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIDGEWAY ESTATES | 103 12TH STREET NE LITTLE FALLS, MN 56345 |

| (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 |
|---|---|---|---|---|
| 01790 | Continued From page 16<br><br>safely sent with the resident or the resident's representative, staff may be instructed to do so.<br>c. If not using original container or a medi-planner, medications should be placed in a medication envelope. This envelope should be labeled with the following information:<br>i. date and time of administration;<br>ii. resident's name<br>d. The staff person who gives the medications to the resident or the resident's representative will document who received the medications, the time and date, the amount of medications in the container, and the name and title of the staff person who gave the medications to the resident or the resident's representative on form CCP.QC.AL.107-F1 Meds to be Given When Away from Home<br>i. The staff person who gives the medications to the resident or the resident's representative will provide a copy of the electronic Medication Administration Record of the resident's current medications that includes any special instructions for administering or handling the medications, including controlled substances."<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01790 | | |
| 01880 SS=D | 144G.71 Subd. 19 Storage of medications<br><br>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.<br><br>This MN Requirement is not met as evidenced | 01880 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30385 | A. BUILDING: _____ B. WING _____ | 09/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIDGEWAY ESTATES | 103 12TH STREET NE LITTLE FALLS, MN 56345 |

| (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 |
|---|---|---|---|---|
| 01880 | Continued From page 17<br><br>by:<br>Based on observation, interview, and record review, the licensee failed to ensure medications were secure and permitted access to only authorized personnel for one of five apartments.<br><br>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).<br><br>The findings include:<br><br>During the entrance conference on September 21, 2026, at 9:45 a.m., clinical nurse supervisor (CNS)-A and licensed assisted living director (LALD)-B stated the licensee provided medication management services to residents at the facility.<br><br>On September 21, 2026, at 10:15 a.m., LALD-B brought the surveyor to a vacant resident apartment to use for the course of the survey. The surveyor observed LALD-B open the door without a key, and observed multiple medications unsecured on the kitchen counter. LALD-B stated at this time the medications should be locked in the cabinet and also said the door to the apartment had been unlocked.<br><br>On September 21, 2026, at 10:50 a.m., CNS-A opened the medication cabinet in the apartment and five sheets of prefilled medications. CNS-A stated the resident had discharged and the licensee was not managing the medications. CNS-A added she did not know the resident's | 01880 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30385 | A. BUILDING: _____ B. WING _____ | 09/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIDGEWAY ESTATES | 103 12TH STREET NE LITTLE FALLS, MN 56345 |

| (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 |
|---|---|---|---|---|
| 01880 | Continued From page 18<br><br>family had left the medications in the apartment to destroy. In addition, CNS-A stated medications should be placed in the locked cabinets.<br><br>The licensee's undated Storage of Medications policy noted the registered nurse (RN) "will identify where medications will be stored understanding that our Care Center may not be able to control where and how a resident stores his/her medications in their apartment."<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01880 | | |
| 02310 SS=D | 144G.91 Subd. 4 (a) Appropriate care and services<br><br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure care and services were provided according to acceptable health care and medical, or nursing standards for one of one resident (R2) with hospital bed rails.<br><br>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 | 02310 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30385 | A. BUILDING: _____ B. WING _____ | 09/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIDGEWAY ESTATES | 103 12TH STREET NE LITTLE FALLS, MN 56345 |

| (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 19<br><br>limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).<br><br>The findings include:<br><br>R2's diagnoses included atherosclerotic heart disease of native coronary artery (where plaque builds up inside of the walls of the arteries), atrial fibrillation (a rapid, irregular heartbeat), and hypertension (high blood pressure).<br><br>R2's Service Plan Detail dated March 1, 2025, indicated R2 received services including assistance with medication administration and housekeeping.<br><br>R2's assessment dated July 2, 2026, noted bedrail measurements as follows:<br>- zone 1 - 4.33 inches;<br>- zone 2 - 4.33 inches; and<br>- zone 3 - 1.97 inches.<br><br>On September 23, 2026, at 2:55 p.m., the surveyor observed R2's bed rails with clinical nurse supervisor (CNS)-A to be a hospital style bed with bilateral hospital bed rails in the raised position. The bed rails were metal material with eight vertical bars between the entire bed rail frame. CNS-A measured the bed rail as follows:<br>- zone 1 (within the rails) from 2 1/2 inches to 3 1.3 inches;<br>- zone 2 (under the rail, between the rail supports or next to a single rail support) 0 inches;<br>- zone 3 (between the rail and the mattress) 2 inches; and<br>- zone 4 (under the rail, at the ends of the rail) 0 inches.<br><br>R2's record lacked accurate documentation of the | 02310 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30385 | A. BUILDING: _____ B. WING _____ | 09/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIDGEWAY ESTATES | 103 12TH STREET NE LITTLE FALLS, MN 56345 |

| (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 20<br>complete bed rail measurements.<br><br>At this time, CNS-A stated she measured the bed rails with the resident in the bed, so they will be slightly different from the measurements in the assessment. However, CNS-A did state the measurements for zone 2 and zone 4 were inaccurate on her assessment.<br><br>The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) last updated December 13, 2024, 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:<br>- Purpose and intention of the bed rail;<br>- Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail;<br>- The resident's bed rail use/need assessment;<br>- Risk vs. benefits discussion (individualized to each resident's risks);<br>- The resident's preferences;<br>- Installation and use according to manufacturer's guidelines;<br>- Bed rail measurements;<br>- Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct | 02310 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30385 | A. BUILDING: _____ B. WING _____ | 09/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIDGEWAY ESTATES | 103 12TH STREET NE LITTLE FALLS, MN 56345 |

| (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 21<br><br>installation; and<br>- Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements".<br><br>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."<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Two (2) days | 02310 | | |

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

# Food & Beverage Inspection Report



## Establishment Info

BRIDGEWAY ESTATES
103 12th Street NE
Little Falls, MN 56345
Morisson County
Parcel:

Phone:

## License Info

License: HFID 30385

Risk:
License:
Expires on:
CFPM: JENNIFER BIERMAIER
CFPM #: 46141; Exp: 10/03/2026

## Inspection Info

Report Number: F1017261195
Inspection Type: Full - Single
Date: 9/21/2026 Time: 12:44:05 PM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

# Food & Beverage General Comment

DISCUSSION

AVOID BARE HAND CONTACT WITH READY TO EAT FOOD, HAND WASHING, EMPLOYEE ILLNESS LOG.

A CONVERSATION WAS HELD WITH MAINTENANCE STAFF AND ERIN HANSON FOOD SERVICE DIRECTOR; STAFF STATED THAT ALL WOOD CABINETS ARE BEING REPLACED AND STAINLESS STEEL COUNTERTOPS ARE GOING TO BE INSTALLED. COUNTERTOPS HAVE BEEN PURCHASED, ARE ONSITE AND STORED IN GARAGE. STOVE AND UPRIGHT COOLER WOULD ALSO NEED TO MEET THE ANSI ACCREDITATION STANDARDS (SEE ATTACHED ANSI PDF).

**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 F1017261195 from 9/21/2026**

SAMANTHA HOFER
ASSISTED LIVING DIRECTOR

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

BRIDGEWAY ESTATES
Little Falls
County/Group: Morisson County

## Inspection Info

Report Number: F1017261195
Inspection Type: Full
Date: 9/21/2026
Time: 12:44:05 PM

**Food Temperature: Product/Item/Unit:** HARD BOILED EGGS **; Temperature Process:** Cold-Holding
**Location:** Upright Cooler at 34 Degrees F.
Comment:
*Violation Issued?: No*

**Food Temperature: Product/Item/Unit:** PEAS**; Temperature Process:** Hot-Holding
**Location:** Steam Table at 198 Degrees F.
Comment:
*Violation Issued?: No*

**Food Temperature: Product/Item/Unit:** MEAT LOAF**; Temperature Process:** Hot-Holding
**Location:** Steam Table at 148 Degrees F.
Comment:
*Violation Issued?: No*

**Food Temperature: Product/Item/Unit:** WILD RICE SOUP**; Temperature Process:** Hot-Holding
**Location:** Steam Table at 192 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

BRIDGEWAY ESTATES
Little Falls
County/Group: Morisson County

## Inspection Info

Report Number: F1017261195
Inspection Type: Full
Date: 9/21/2026
Time: 12:44:05 PM

**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:** Dispenser
**Location:** Kitchen **Equal To** 400 PPM
Comment:
*Violation Issued?: No*

Minnesota (MDH) Version
EH Manager; RPT: F1017261195

# 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: 9/21/2026 |
| No. of Repeat Risk Factor/Intervention/Violations | | Time: 12:44:05 PM |
| Score (optional) | | Dur: min |

| Establishment: | Address: | City/State: | Zip: | Phone: |
|---|---|---|---|---|
| BRIDGEWAY ESTATES | 103 12th Street NE | Little Falls, MN | 56345 | |
| **License/Permit #:** | **Permit Holder:** | **Purpose of Inspection:** | **Est. Type:** | **Risk Category:** |
| HFID 30385 | | 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 | N/O | Proper eating, tasting, drinking, tobacco use | | |
| 7 | N/O | 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 | IN | 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 | N/O | Proper date marking & disposition | | |
| 24 | N/A | Time as public health control;procedures & record | | |
| | **Consumer Advisory** | | | |
| 25 | IN | 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 | 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 | | 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:

# Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

| | |
|---|---|
| **Project No:** SL30385016-0 | **Date:** September 23, 2026 |
| **Facility Name:** Bridgeway Estates | |
| **Facility Address:** 103 12th st NE little falls, MN 56345 | |

☒ **TAG IDENTIFICATION: 0775**

**SCOPE/ SEVERITY:** Level 2; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]

2. Single- and multiple-station smoke alarms shall be replaced when they fail to respond to operability tests or exceed ten years from the date of manufacture. Smoke alarms shall be replaced with smoke alarms having the same type of power supply. [Minn. Stat. 144G.45 subd. 2; MSFC 1103.8.1]

   *Comments: Several resident rooms contained smoke alarms with a manufacture date of February 2013. Smoke alarms have a service life of 10 years; therefore, the devices identified have exceeded their usable lifespan and may not provide reliable detection. The facility failed to ensure required replacement of outdated smoke alarms.*

☒ **TAG IDENTIFICATION: 0810**

**SCOPE/ SEVERITY:** Level 2; Widespread **TIME PERIOD OF CORRECTION:** Twenty One (21) days

1. Evacuation drills are required for employees 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. [Minn. Stat. 144G.45 subd.2]

   *Comments: 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 showed that drills were conducted until October of 2025 then a gap until July of 2026, not meeting the required frequency of every other month.*