Electronically Delivered

August 19, 2025

Licensee
Peaceful Living LLC
1687 Fallbrooke Drive
Hastings, MN 55033

RE: Project Number(s) SL31220016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 2, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 2: a fine of $500 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

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

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

The correction order documentation should include the following:

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

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

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

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

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in

a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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

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

If you have any questions, please contact me.

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 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
	31220	A. BUILDING: _____ B. WING _____	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACEFUL LIVING LLC	1687 FALLBROOKE DRIVE HASTINGS, MN 55033

(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: SL31220016-0 On June 30, 2025, through July 2, 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 seven residents; seven 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 out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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

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0 480	Continued From page 2 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 July 1, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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0 480	Continued From page 3 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complies with accepted health care, medical and nursing standards for infection control related to glove use and handwashing by one of three unlicensed personnel (ULP-D) during medication administration and blood sugar checks. This had the potential to affect all residents and staff due to cross contamination. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic	0 510		

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0 510	Continued From page 4 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On June 30, 2025, at 12:10 p.m., the surveyor observed ULP-D don (apply) gloves, set up one medication for R5 in a medication cup, went to R5's room and administered the medication. ULP-D returned to the medication room, removed her gloves and documented the medication administration on the electronic medication administration record (EMAR) on the computer. At 12:15 p.m., ULP-D donned a clean pair of gloves, opened the medication cart and obtained R2's nasal spray. ULP-D went to R2's room, handed R2 a Kleenex to first blow his nose and handed him the bottle of nasal spray. R2 self-administered the nasal spray while ULP-D observed and handed the nasal spray bottle back to ULP-D. ULP-D returned to the medication room removed her gloves and documented the nasal spray on the EMAR. ULP-D did not sanitize her hands following the use of gloves and in between residents and contact with multiple surfaces. On July 1, 2025, at 6:39 a.m., the surveyor observed ULP-D don gloves, gather blood sugar equipment, and went to R2's room. ULP-D poked R2's finger to obtain a drop of blood and placed the drop of blood onto the test strip and noted a blood sugar reading of 69. ULP-D stated the reading was below the preferred level and would contact the on call registered nurse (RN). ULP-D then gathered the equipment and went to the medication room and disposed of the test strip and lancet (used to poke the finger) into the sharps container. ULP-D (with the same gloves) unlocked the medication cart and placed R2's	0 510		

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0 510	Continued From page 5 monitoring equipment in the cart. ULP-D locked the cart, removed her gloves (did not sanitize hands) and went to the computer, documented the blood sugar readings, and then went to the office phone and called the on-call RN. The RN gave instructions for ULP-D to give apple juice and recheck the blood sugar in 30 minutes. ULP-D went to the supply room and obtained a single serving bottle of apple juice and took to R2 to drink. At 6:50 a.m., ULP-D obtained a new pair of gloves (no observed hand hygiene from contact with R2), gathered R1's blood sugar equipment from the medication cart, locked the cart and went to R1's room and obtained a drop of blood for his blood sugar check. ULP-D returned the equipment to the medication room, disposed of the test strip and lancet to the sharps container, opened the medication cart, placed R1's blood sugar equipment to the drawer, locked the cabinet, documented R1's blood sugar result on the computer, and left the medication room to go downstairs (opening the gate) with the same gloves still on. ULP-D did not sanitize her hands following her use of gloves with R2's blood sugar check, in between resident contact (between R2 and R1), and following R1's blood sugar check and touching multiple surfaces with the same gloves following R1's blood sugar check. On July 1, 2025, at 8:50 a.m., clinical nurse supervisor (CNS)-B stated he expected and has trained staff to wash or sanitize hands between resident contact and after glove use with potential bloodborne contact. The licensee's Gloves policy dated August 1, 2021, indicated gloves must be worn whenever	0 510		

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0 510	Continued From page 6 there may be direct contact between any employee and contaminated objects or as instructed, and included the following steps: 1. Wash hands 2. Apply gloves to both hands 3. Remove contaminated materials 4. Place materials in proper receptacle 5. Remove gloves by grasping cuff of one glove and pulling it off, turning it inside out. 6. Dispose used gloves in proper receptacle. 7. Rewash hands. The licensee's Handwashing policy dated August 1, 2021, indicated hand washing will be performed by all employees, as necessary, between tasks and procedures, and after bathroom use, to prevent cross-contaminations. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
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 or unusual resident needs for movement or evacuation.	0 810		

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0 810	Continued From page 7 (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content. 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 the residents). The findings include: On June 30, 2025, from 2:30 p.m. to 4:30 p.m.,	0 810		

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0 810	Continued From page 8 the surveyor toured the facility with executive director (ED)-C., FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "Fire Policy", dated 08/01/2021, failed to include the following: STAFF ACTIONS: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate). The provided FSEP was from a third-party provider and had not been updated to the specific facility. UNIQUE AND UNUSUAL RESIDENT NEEDS: The facility uses an electronic care plan website for standard resident evacuation procedures. The FSEP does not include instructions on how to use or what do in the loss of power/internet event for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. On June 30, 2025, at 3:30 p.m., ED-C stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date	01640		

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01640	Continued From page 9 that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included a signature or other authentication by the resident and the facility to document agreement on the services provided for three of three residents (R1, R4, R5). 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).	01640		

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01640	Continued From page 10 The findings include: On June 30, 2025, at 1:00 p.m. during the entrance conference, executive director (ED)-C stated she and the nurse created and updated the Service Plans annually and as services changed. R1 R1 began receiving services from the licensee on September 29, 2020. On July 1, 2025, at 6:45 a.m., the surveyor observed unlicensed personnel (ULP)-D complete R1's blood sugar check. R1's Service Plan Modification (used as the Service Plan) dated July 1, 2025, (after survey started) indicated he received medication management, the treatments of blood sugar checks and compression stockings, management of external urinary catheter, assistance with dressing, bathing, and mechanical lift transfers. R4 R4 began receiving services from the licensee on June 19, 2017. On June 30, 2025, at 4:00 p.m., the surveyor observed ULP-F interact with R4 upon his return home from and out of facility activity. R4's Service Plan Modification dated July 1, 2025, (after survey started), indicated he received services to include medication management, assistance with dressing, bathing, grooming, behavior management, and transfers. R5	01640		

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01640	Continued From page 11 R5 began receiving services from the licensee on February 12, 2020. On June 30, 2025, at 12:10 p.m., the surveyor observed ULP-D administer R5's afternoon medication. R5's Service Plan Modification dated July 1, 2025, (after survey started), indicated she received services to include medication management, behavior management, and oral care assistance. R1, R4, and R5's Service Plans lacked a signature by the resident or resident representative or facility representative to document agreement on the services provided to them prior to the time of survey. On July 2, 2025, at 9:30 a.m., ED-C stated she was unable to locate the above listed resident's signed Service Plans as completed last year (July 2024). She stated the licensee had updated them last then and had either had the Service Plans signed in person, or docu-signed by the resident's guardian; however, she was not able to find where the Service Plans were stored either by paper copy or uploaded to the computer system. ED-C stated the licensee had experienced turn over in both the nursing department and in the Human Resources department who helped with records. ED-C stated she had reached out to the guardians of the above listed residents, who in turn indicated they were sure they signed something but were not able to find record either. ED-C stated she had not yet looked, but assumed the remaining four resident's Service Plan signatures would likely not be found. The licensee's Service Plan policy dated August	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31220	A. BUILDING: _____ B. WING _____	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACEFUL LIVING LLC	1687 FALLBROOKE DRIVE HASTINGS, MN 55033

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01640	Continued From page 12 1, 2021, indicated any revisions to the Service Plan are signed by a representative from (facility name) and the resident or resident's representative, indicating agreement with the services to be provided. No further information was provided. TIME PERIOD TO CORRECT- Twenty-one (21) days.	01640		
01830 SS=D	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to renew prescriptions at least every 12 months for one of three residents (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R4	01830		

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	31220	A. BUILDING: _____ B. WING _____	07/02/2025

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PEACEFUL LIVING LLC	1687 FALLBROOKE DRIVE HASTINGS, MN 55033

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01830	Continued From page 13 R4 began receiving services on June 19, 2017. R4's Service Plan Addendum dated July 1, 2025, (signed after survey started), indicated R4 received medication administration. On July 1, 2025, at 7:15 a.m., the surveyor and unlicensed personnel (ULP)-D reviewed the medication cart contents and noted R4's pseudoephedrine 30 milligram (mg) tablets (used for nasal congestion/cold symptoms) bubble card indicated an expiration date of May 2025. On July 1, 2025, at 9:05 a.m., the surveyor requested R4's signed medication orders. On July 1, 2025, at 11:00 a.m., the surveyor was provided a pharmacy list of R4's medication orders and indicated pseudoephedrine 30 mg by mouth every six hours as needed for nasal congestion. The original order was dated May 16, 2024. On July 1, 2025, at 12:00 p.m., ULP-D stated R4 received his morning medications earlier in the day. On July 1, 2025, at 3:15 p.m., clinical nurse supervisor (CNS)-B provided the surveyor with R4's pseudoephedrine order dated July 1, 2025. CNS-B stated he just renewed the order as he noted the previous signed order had expired on May 16, 2025. The licensee failed to ensure R4's pseudoephedrine order was renewed every 12 months as required. The licensee's Medication and Treatment Order Renewal policy dated August 1,2021, indicated	01830		

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	31220	A. BUILDING: _____ B. WING _____	07/02/2025

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01830	Continued From page 14 residents who receive medication management services by licensee name will have a current physician prescribed medication or treatment/therapy orders on record. Medication and treatment orders must be renewed at least every 12 months or more frequently as required. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01830		
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure stored medications were not expired for three of seven residents (R1, R4, R5) with medication administration. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31220	A. BUILDING: _____ B. WING _____	07/02/2025

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01890	Continued From page 15 found to be pervasive). The findings include: R1 R1's Service Agreement Addendum (used as the Service Agreement) dated July 1, 2025, (signed after survey started) received the service of medication management/administration. R1's signed prescriber's orders dated August 15, 2024, indicated fluocinonide cream 0.05 %, apply topically (to skin) to affected areas twice daily as needed for blisters on legs. On July 1, 2025, at 7:15 a.m., the surveyor and unlicensed personnel (ULP)-D reviewed the contents of the licensee's medication cart and noted R1's fluocinonide 0.05% cream had an expiration date of August 2024. The tube was partially used. R4 R4's Service Agreement and Care plan dated July 1, 2025, (signed after the start of survey), indicated he received the service of medication management/administration. R4's signed prescriber's orders dated July 1, 2025, (order signed after survey started) indicated pseudoephedrine 30 mg, give one tablet by mouth every six hours as needed for nasal congestion. On July 1, 2025, at 7:15 a.m., the surveyor and ULP-D reviewed the contents of the licensee's medication cart and noted R4's pseudoephedrine 30 mg bubble card included 51 tablets and indicated an expiration date of May 2025.	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01890	Continued From page 16 R5 R5's Service Agreement Addendum dated July 1, 2025, (signed after the start of survey), indicated she received the service of medication management/administration. R5's signed prescriber's orders dated August 20, 2024, and May 16, 2025, indicated: -guanfacine 1 mg, give one tablet orally scheduled daily in the morning and one tablet (1 mg) as needed once daily for anxiety or irritability. Wait at least one hour between doses; and -trazodone 50 mg one tablet by mouth at bedtime for sleep On July 1, 2025, at 7:15 a.m., the surveyor and ULP-D reviewed the contents of the licensee's medication cart and noted: - guanfacine 1 mg bubble card with 11 remaining tablets indicated an expiration date of June 10, 2025; and - trazodone 50 mg bubble card with 30 remaining tablets indicated an expiration date of May 30, 2025. The licensee failed to ensure R1, R4, and R5's medications had not exceeded the expiration date. On July 1, 2025, at 8:30 a.m., executive director (ED)-C stated there should be no expired medications in the medication cart as the staff are assigned and complete a task check off indicating no expired medications. When shown the expired medications found, ED-C stated they were expired, and she would follow up with staff. The licensee's Prescription Drugs and Prohibition policy dated August 1, 2021, indicated when	01890		

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01890	Continued From page 17 (licensee name) receives a prescription drug, prior to being set up for immediate or later administration, the prescription drug must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Peaceful Living LLC
1687 Fallbrooke Drive
Hastings, MN 55033
Dakota County
Parcel:

Phone:

License Info

License: HFID 31220

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

Inspection Info

Report Number: F1036251029
Inspection Type: Full - Single
Date: 7/1/2025 Time: 2:10:29 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 1
Delivery:

New Order: 2-100 Supervision
2-102.12AMN *Priority Level: Priority 3 CFP#: 2*
MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.
COMMENT: NO CURRENT MDH CFPM AT ESTABLISHMENT. INFORMATION FOR APPLICATION SENT ALONG WITH REPORT.
Comply By: 7/1/2025 Originally Issued On: 7/1/2025

Food & Beverage General Comment

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. SURVEYOR FROM HRD WAS DEB JACOBSON. INSPECTION CONDUCTED IN PRESENCE OF MICHAEL GARVEY, THE PERSON IN CHARGE.

THIS FACILITY DOES NOT HAVE COMMERCIAL GRADE ANSI EQUIPMENT. ALL FOOD MUST BE SERVED THE SAME DAY IT IS PREPARED, AND LEFTOVERS CAN NEVER BE SAVED.
FOOD SERVICE AREA FLOORS, WALLS, CEILINGS, COUNTERTOPS, AND FINISH MATERIALS MUST BE NON-ABSORBANT, SMOOTH, DURABLE, AND EASILY CLEANABLE. CEILINGS CANNOT HAVE POPCORN TEXTURE. CABINETS CANNOT HAVE HOLLOW BASES. EXPOSED WOOD IS NOT APPROVED FOR FOOD SERVICE AREAS. WOOD IS NOT AN APPROVED FOOD CONTACT SURFACE.

DISCUSSED ALL ORDERS ON SITE IN ADDITION TO THE FOLLOWING WITH THE PERSON IN CHARGE:
- EMPLOYEE ILLNESS LOG AND EXCLUSION POLICY.
- HAND WASHING POLICY AND REVIEW.
- PROPER FOOD STORAGE.
- GLOVE USAGE.
- THERMOMETER USE AND CALIBRATION.
- DATE MARKING.
- PEST CONTROL.
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS.

- ANSI 184 STANDARD FOR RESIDENTIAL DISH WASHER.

FOR CORRECT BY DATES REFER TO COMPLETE REPORT ISSUED BY HRD.

**IF ANY RESIDENT COMPLAINS OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE CUSTOMER. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.

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 Metro District Office inspection report number F1036251029 from 7/1/2025

Jeff Johanson

MICHAEL GARVEY
PERSON IN CHARGE

Jeff Johanson,
Public Health Sanitarian 1
651-201-4349
jeff.johanson@state.mn.us