Electronically Delivered

November 21, 2025

Licensee
Boka Haven Inc
5251 386th Street
Branch, MN 55056

RE: Project Number(s) SL40189015

Dear Licensee:

On November 17, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on August 7, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Kelly Thorson, Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

HHH

Electronically Delivered

September 23, 2025

Licensee
Boka Haven Inc
5251 386th Street
Branch, MN 55056

RE: Project Number(s) SL40189015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial survey on August 7, 2025, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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

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

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

§ 144G.20;

Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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

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

The total amount you are assessed is $2,000.00. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per 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 residents/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 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 the Department of Health 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 MDH 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,

Kelly Thorson

Kelly Thorson, Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.us
Telephone: 320-223-7336 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
	40189	A. BUILDING: _____ B. WING _____	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOKA HAVEN INC	5251 386TH STREET BRANCH, MN 55056

(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: SL40189015 On August 4, 2025, through August 7, 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 20 residents; 18 receiving services under the Provisional Assisted Living Facility license. An immediate correction order was identified on August 5, 2025, issued for SL40189015, tag identification 1290. During the course of the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained and the scope and level remain unchanged.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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0 480	Continued From page 1	0 480		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink;	0 480		

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0 480	Continued From page 2 (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated August 4, 2025, for the specific	0 480		

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0 480	Continued From page 3 Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed or included a review/assessment of the person's risk of abusing other vulnerable adults and statements of the specific measures to be taken to minimize the risk of abuse for two of two residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 630		

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0 630	Continued From page 4 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 the residents). The findings include: During the entrance conference on August 4, 2025, at 11:49 a.m., clinical nurse supervisor (CNS)-B stated the licensee was familiar with current minimum assisted living requirements. R2 R2 was admitted and began receiving assisted living services on September 5, 2024. R2's IAPP dated July 23, 2025, lacked an assessment of R2's risk of abusing other vulnerable adults. R3 R3 was admitted and began receiving assisted living services on March 13, 2025. R3's IAPP dated June 5, 2025, lacked an assessment of R3's risk of abusing other vulnerable adults. On August 4, 2025, at 11:23 a.m. CNS-B stated the previous registered nurse (RN) had not been completing them as required and the assessments needed to be updated. CNS-B stated she was aware of the requirements for the IAPP's. The licensee's Individual Abuse Prevent Plans policy dated November 8, 2024, indicated an individual abuse prevention plan is developed for each assisted living resident. The individual	0 630		

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0 630	Continued From page 5 abuse prevention plan will include: a. Individualized review or assessment of the resident's susceptibility to be abused by another individual, including other vulnerable adults b. The resident's risk of abusing other vulnerable adults c. Specific measures to minimize the risk of abuse to that person and other vulnerable adults. d. Measure to minimize the risk of self-abuse, if applicable. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 775 SS=I	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with Minnesota State Fire Code in Minnesota Rules chapter 7511. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level three violation (is a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 775		

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0 775	Continued From page 6 The findings include: On August 6, 2025, at approximately 9:30 a.m., the surveyor toured the facility with maintenance (M)-D. The following was observed. All the resident room doors in the facility are rated fire doors with tags on the door frame and hinge side of the door, smoke seal, and closers. The resident room doors are also equipped with kick down style door hold open devices. It was observed that most of the resident room doors were propped open with no staff providing patient care or cleaning services. Fire doors and smoke and draft control doors shall not be blocked, obstructed, or otherwise made inoperable. On August 6, 2025, M-D acknowledged the observation while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique	0 810		

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0 810	Continued From page 7 or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of	0 810		

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0 810	Continued From page 8 the residents). The findings include: On August 6, 2025, maintenance (M)-D provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP failed to include the following: The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. On August 6, 2025, M-D stated they understood the area of the policy that was incomplete and would work to bring the FSEP into compliance. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. M-D lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. On August 6, 2025, M-D stated they understood the requirements for training residents and would implement a training program that was compliant with statute requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		

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01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was submitted and completed for the current health facility identification (HFID) number for one of one employee (housekeeper (HK)-C) on the facility provided employee roster. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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 the residents). This resulted in an immediate correction order	01290		

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01290	Continued From page 10 issued on August 5, 2025. The findings include: On August 4, 2025, at 12:42 p.m., the surveyor reviewed the facility's NetStudy 2.0 roster and compared it to the facility's staff roster and discovered one of the facility's employees was not listed as having a background study submitted with the licensee's HFID 40189. HK-C was hired on December 3, 2024, to provide housekeeping services to the licensee's residents. HK-C provided housekeeping services without direct supervision on July 1, 7, 8, 14, 15, and August 4, 2025. A background study had been completed on December 18, 2024; however HK-C did not fulfill the fingerprint requirement and the background study was closed on January 2, 2025. On August 4, 2025, at 3:04 p.m., clinical nurse supervisor (CNS)-B stated background studies are completed for all employees. On August 4, 2025, at 4:27 p.m., CNS-B stated, "we're thinking maybe she didn't get sent to fingerprinting and that is why it's not showing up". The licensee's Background Checks policy dated November 8, 2024, indicated all employees of the facility with direct resident contract will undergo a background study through DHS (Department of Health Services). Only those with satisfactory results will continue to work with the facility and its residents. No further information was provided.	01290		

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01290	Continued From page 11 TIME PERIOD FOR CORRECTION: IMMEDIATE	01290		
01530 SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is	01530		

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	40189	A. BUILDING: _____ B. WING _____	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOKA HAVEN INC	5251 386TH STREET BRANCH, MN 55056

(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
01530	Continued From page 12 complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received eight hours of initial dementia care training within the first 160 hours worked for one of one employee (unlicensed personnel (ULP)-E). In addition, the licensee failed to ensure supervisors of direct care staff received the required 2 hours of initial training on mental illness and de-escalation topics within 120 hours of start date for one of one employee (owner/licensed assisted living director (O/LALD)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on August 4, 2025, at 12:02 a.m., clinical nurse supervisor (CNS)-B stated the licensee was aware of the required contents of the employee record.	01530		

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	40189	A. BUILDING: _____ B. WING _____	08/07/2025

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01530	Continued From page 13 ULP-E began employment on November 21, 2024, to provide direct care services. On August 4, 2025, at 1:58 p.m., the surveyor observed ULP-E prepare and administer medications for residents. ULP-E's orientation and training record lacked documentation of the required number of hours of dementia care training. The training record dated November 25, 2024, included: -Dementia introduction and overview 1.0 -Dementia 2- Communication 1.25 -Dementia 3 Activities of Daily Living 1.0 -Dementia 4 Behaviors vs Symptoms 1.0 -Dementia 5 the Journey .75 O/LALD-A began employment on March 15, 2021, to provide supervision and oversite to unlicensed staff. O/LALD-A's orientation and training record lacked documentation of any of the required number of hours of mental illness and de-escalation training. On August 6, 2025, at 11:26 a.m., CNS-B stated she was not aware ULP-E had five (5) hours of dementia training and not eight (8) hours as required. She stated a previous employee was assigning the training modules in Educare (electronic training program) and she does not know why it was not assigned. On August 11, 2025, at 1:13 p.m., O/LALD-A stated "the mental health course must have been overlooked. I know they were assigned to staff but not added to my list. I will complete them	01530		

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	40189	A. BUILDING: _____ B. WING _____	08/07/2025

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BOKA HAVEN INC	5251 386TH STREET BRANCH, MN 55056

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01530	Continued From page 14 soon". The licensee's undated Assisted Living Dementia Training policy indicated direct-care staff will complete a minimum of 8 hours of initial training on dementia care topics, initial training will be completed within 160 working hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services;	01620		

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01620	Continued From page 15 (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure the registered nurse (RN) conducted a comprehensive assessment within 14 days following a residents admission date and failed to ensure the RN conducted ongoing reassessment and monitoring on or before day 90 for one of one resident (R2). This practice resulted in a level two violation (a	01620		

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	40189	A. BUILDING: _____ B. WING _____	08/07/2025

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01620	Continued From page 16 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: On August 4, 2025, at 10:56 a.m., during the entrance conference, clinical nurse supervisor (CNS)-B stated a registered nurse completed resident assessments prior to admission, admission, 14-day, every 90 days, and with a change in condition. R2 began receiving assisted living services on September 5, 2024. R2's record indicated a 14-day comprehensive nursing assessment was completed on September 30, 2024, 25 days after admission. In addition, a 90-day comprehensive nursing assessment was completed on January 3, 2025, 95 days apart. On August 4, 2025, at 11:28 a.m., CNS-A stated she was aware of the late assessments conducted by the previous RN. She stated she was hired in April 2025 and has been completing assessments to meet the requirements. The licensee's undated Initial and On-Going Nursing Assessment of Residents policy indicated a RN will complete the following comprehensive nursing assessments of the resident's physical, mental and cognitive needs	01620		

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01620	Continued From page 17 as required: a. pre-admission assessment b. 14-day assessment completed up to 14-days after start of services c. ongoing assessment completed periodically but no less than every 90-days d. change in resident condition No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01890 SS=F	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 date time-sensitive medications with an opened or expired date for two of two residents (R5, R6) and failed to keep a medication in its original container bearing the original prescription label for one of one resident (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	01890		

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01890	Continued From page 18 problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on August 4, 2025, at 11:52 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents. On August 4, 2025, at 2:06 p.m., the surveyor observed the medication cart with unlicensed personnel (ULP)-E. The medication cart held a glargine insulin pen for R6 that was not marked with an opened or expiration date and a Spiriva Respimat inhaler that was not marked with an opened or expiration date for R5. In addition, there was a bottle of ciprofloxacin dexamethasone ear drops lacking the pharmacy prescription label. On August 4, 2025, at 2:18 p.m., ULP-E stated she was trained to write the open date and her initials on insulin labels. ULP-E stated she was not trained to indicate the open date on any other medications. On August 4, 2025, at 2:58 p.m., CNS stated staff are trained to date and initial all time sensitive medications when opened. She stated, "we may have run out of the stickers we use". The manufacturer's instructions for storing glargine insulin dated July 28, 2021, indicated to discard unused medication 28 days from open date. The manufacturer's instruction for storing Spiriva	01890		

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01890	Continued From page 19 Respimat inhaler dated September 2015, indicated to throw away three (3) months after insertion of cartridge into inhaler, even if all the medicine has not been used, or when the inhaler is locked, whichever comes first. The licensee's Assisted Living Orientation All Staff policy dated November 8, 2024, indicated unlicensed personnel is educated and trained in the proper methods to administer medications and medication is in the original pharmacy dispensed container with a proper label and directions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards with regards to safely storing oxygen for one of one resident (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or	02310		

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	40189	A. BUILDING: _____ B. WING _____	08/07/2025

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BOKA HAVEN INC	5251 386TH STREET BRANCH, MN 55056

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02310	Continued From page 20 safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: During the entrance conference on August 4, 2025, at 12:01 p.m., clinical nurse supervisor (CNS)-B stated the licensee provided oxygen management to residents at the facility. On August 5, 2025, at 10:58 a.m., the surveyor observed several upright oxygen tanks stored in two (2) storage racks in R5's living room. In addition, there were two (2) oxygen tanks located behind R5's reclining chair. One (1) oxygen tank was in a wheeled oxygen tank cart, one (1) larger oxygen tank was unsecured. On August 5, 2025, at 11:00 a.m., unlicensed personnel (ULP)-F stated she was trained to place all oxygen tanks in a stand/holder to prevent them from falling over. On August 5, 2025, at 11:16 a.m., CNS-B stated she did not realize the oxygen provider had not supplied a stand/holder for the large oxygen tank. She stated she was aware of the requirements for storing oxygen and all ULP's are trained to secure oxygen tanks in a stand/holder. The Minnesota Department of Health (MDH) Oxygen Cylinder Storage Requirements dated April 16, 2020, based on the National Fire Protection Association, Standard 99 (NFPA 99), indicated a common hazard in a health care	02310		

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02310	Continued From page 21 facility is storing and handling compressed oxygen in cylinders. When storing oxygen cylinders, they must be secured in racks or by chains to prevent them from falling over. The licensee's Oxygen Use policy dated August 6, 2024, indicated compressed oxygen cylinders will be stored upright, secured with chains or stands. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

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

BOKA HAVEN INC
5251 386TH STREET
North Branch, MN 55056
Chisago County
Parcel:

Phone:

License Info

License: HFID 40189

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

Inspection Info

Report Number: F1025251077
Inspection Type: Full - Single
Date: 8/4/2025 Time: 2:00 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 1
Total Priority 2 Orders: 2
Total Priority 3 Orders: 2
Delivery:

! **New Order: 3-500B Microbial Control: hot and cold holding**
3-501.16A2 *Priority Level: Priority 1 CFP#: 22*
MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.
COMMENT: Milk, dressings, yogurt used by care staff for residents at 47 deg F in the neighborhood kitchen refrigerator. Maintain all cold TCS foods for residents at or below 41 deg F.
Comply By: 8/4/2025 Originally Issued On: 8/4/2025

New Order: 4-200 Equipment Design and Construction
4-201.11AMN *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0506A Provide or replace food service equipment with equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.
COMMENT: Residential refrigerator in the neighborhood kitchen does not meet the above requirements. Because the facility cools TCS foods, MN 4626.0506G does not apply. All TCS foods for residents must be maintained at or below 41 deg F in equipment which meets the above requirements.

The neighborhood kitchen refrigerator can be used for personal items or non TCS foods. The freezer on the bottom may be used for items, as freezers do not to meet the above requirement.
Comply By: 8/4/2025 Originally Issued On: 8/4/2025

New Order: 4-300 Equipment Numbers and Capacities
4-301.11 *Priority Level: Priority 2 CFP#: 33*
MN Rule 4626.0675 Provide equipment in sufficient number and capacity for cooling, heating and hot and cold holding of food to maintain foods at proper temperatures.
COMMENT: Establishment has two (2) 2-door upright coolers to be used for cooling and cold holding, and one walk-in freezer. Coolers are currently at storage capacity, taking into account that TCS food must be cooled in shallow metal pans uncovered (cannot stack things on top of items while cooling) and raw animal foods must be stored under ready-to-eat foods.

Note that the residential refrigerator in the neighborhood kitchen does not meet the requirements of MN4626.0506 and cannot be used for TCS foods. TCS foods in this cooler need to be moved to one of the kitchen coolers, but there isn't really much room for additional cartons of milk, yogurt, and dressings while still maintaining space for cooling food volume.

Provide an adequate number of coolers for the facility. Facility current has 20 residents, but reported residential room for 40; if food volume is to be increased, then additional cold holding capacity will need to be added to the establishment.
Comply By: 8/4/2025 Originally Issued On: 8/4/2025

New Order: 4-300 Equipment Numbers and Capacities
4-302.13B *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.
COMMENT: Provide a means of testing the internal contact temperature in the dish machine, options and testing frequency discussed
Comply By: 8/8/2025 Originally Issued On: 8/4/2025

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control
6-501.11 *Priority Level: Priority 3 CFP#: 55*
MN Rule 4626.1515 Maintain the physical facilities in good repair.
COMMENT: Pour floor is missing coating in some spots - these spots appear to be concrete and color broadcast but lack the top layer coating. These spots are not smooth or easily cleanable. Repair the areas in the floor lacking the proper finish.
Comply By: 9/30/2025 Originally Issued On: 8/4/2025

Food & Beverage General Comment

Discussed cooling TCS foods. Use shallow metal pans and cool uncovered while in the cooler. Once down to 41 deg F in six hours, foods can then be transferred to a covered or plastic storage container.

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 F1025251077 from 8/4/2025

Danielle

Casey Kipping, MA RS
Public Health Sanitarian 3
651-201-4513
casey.kipping@state.mn.us

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Sanitizer Observations/Recordings

Establishment Info

BOKA HAVEN INC
North Branch
County/Group: Chisago County

Inspection Info

Report Number: F1025251077
Inspection Type: Full
Date: 8/4/2025
Time: 2:00 PM

New Record: **Product:** Dish machine**; Sanitizing Process:** High temp
Location: Dishwashing Area **Equal To**
Comment: 160 deg F contact (x2 cycles)
190 deg F rinse
20 PSI
Violation Issued?: No

Minnesota (MDH) Version
EH Manager; RPT: F1025251077

Food Establishment Inspection Report

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

No. of Risk Factor/Intervention/Violations	1	Date: 8/4/2025
No. of Repeat Risk Factor/Intervention/Violations		Time: 2:00 PM
Score (optional)		Dur: min

Establishment:	Address:	City/State:	Zip:	Phone:
BOKA HAVEN INC	5251 386TH STREET	North Branch, MN	55056	
License/Permit #:	**Permit Holder:**	**Purpose of Inspection:**	**Est. Type:**	**Risk Category:**
HFID 40189		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

			COS	R
		Safe Food and Water		
30	IN	Pasteurized eggs used where required		
31		Water & ice from approved source		
32	N/A	Variance obtained for specialized processing methods		
		Food Temperature Control		
33	X	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	X	Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48	X	Warewashing facilities: installed, maintained, used; test strips		
49		Non-food contact surfaces clean		
		Physical Facilities		
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities; properly constructed, supplied & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55	X	Physical facilities installed, maintained & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing and plan review		

Person in Charge (signature)

Inspector (signature)

Follow-up: Follow-up Date: