Electronically Delivered

October 17, 2025

Licensee
Minnehaha Care
1477 Minnehaha Ave East
Saint Paul, MN 55106

RE: Project Number(s) SL41394015

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 September 10, 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.

The Department of Health 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. 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 . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

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

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,

Renee L Anderson

Renee Anderson, Supervisor
State Evaluation Team
Email: Renee.L.Anderson@state.mn.us
Telephone: 651-201-5871 Fax: 1-866-890-9290

KKM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41394	A. BUILDING: _____ B. WING _____	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNEHAHA CARE	1477 MINNEHAHA AVE E SAINT PAUL, MN 55106

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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: SL41394015-0 On September 8, 2025, through September 10, 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 10 residents; 10 receiving services under the Provisional 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.	
0 640 SS=C	144G.42 Subd. 7 Posting information for reporting suspected c	0 640		

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0 640	Continued From page 1 The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to support protection and safety by failing to post the 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect 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: During a facility tour on September 8, 2025, at approximately 1:30 p.m., the surveyor observed a telephone on a table in the common area near the front door. There was no 911 posting near the	0 640		

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0 640	Continued From page 2 telephone. On September 8, 2025, at 1:30 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the telephone near the front door was the phone residents could use and she was not aware 911 need to be posted near the telephone. The licensee's 2.21 Emergency/911 policy, dated May 25, 2025, directed staff to call 911 to summon assistance when handling an emergency, but did not indicate 911 should be posted near telephones used by residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
0 810 SS=C	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. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans	0 810		

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0 810	Continued From page 3 upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content, and provide the required training. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include:	0 810		

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0 810	Continued From page 4 On September 10, 2025, at 9:45 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A, 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 provided FSEP, failed to include the following: The available FSEP did not identify specific fire protection actions for residents as evident by not providing procedures for residents to take in this specific facility in the event of a fire or similar emergency in writing in the FSEP. TRAINING Record review of the available documentation indicated the licensee failed to provide evacuation training to residents at least once per year as evident by not providing documentation the resident training was provided as required. It was explained that the resident actions to take during a fire or similar emergency and training provided are required to be included in the FSEP for residents that are capable of assisting in their own evacuation. During an interview on September 9, 2025, at 12:15 p.m., LALD/CNS-A, stated resident procedure required in the event of a fire or similar emergency were not provided in the FSEP. LALD/CNS-A, also stated documentation was not available indicating residents were provided training based on FSEP at least annually.	0 810		

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0 810	Continued From page 5 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
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	01530		

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01530	Continued From page 6 new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure direct care staff received the required 2 hours of initial training on mental illness and de-escalation topics within 160 hours of start date for two of two employees (licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A, unlicensed personnel (ULP)-B). 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). The findings include: LALD/CNS-A was hired May 25, 2025, and provided management of the day to day operations, supervision of staff, and direct cares and services for residents of the facility. ULP-B was hired May 26, 2025, and provided direct cares and services for residents of the	01530		

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01530	Continued From page 7 facility. ULP-B's online training transcript indicated ULP-B completed one hour of mental illness training on June 27, 2025. LALD/CNS-A and ULP-B's employee records lacked documentation they completed the required 2 hours of initial training on mental illness and de-escalation topics within 160 hours of start date, effective July 1, 2025. On September 10, 2025, at 11:00 a.m., LALD/CNS-A stated they had a variety of training in a care providers summit that offered mental illness and de-escalation topic sessions, but did not get any documentation of specific sessions attended. LALD/CNS-A further stated they thought the full two hours of mental illness de-escalation training would be due by the end of the year, and added that another hour was scheduled for the ULPs to completed in October. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01820 SS=F	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record	01820		

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01820	Continued From page 8 review, the licensee failed to ensure there were current written or electronically recorded prescriptions as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility was managing for two of two residents (R1, R2). 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: R1 R1's service plan dated June 4, 2025, indicated R1 received services to include assistance with medication administration, three times daily. R1's medication administration record (MAR) for September 2025, indicated R1 was scheduled to take the following medications: -allopurinol (for kidney stones and gout) 100 milligrams (mg) 1 tablet every 48 hours (hrs) by mouth, -clopidogrel (blood thinner) 75 mg 1 tab by mouth daily, -ferrous sulfate (iron supplement) 325 mg 1 pill by mouth daily, -losartan potassium (for blood pressure) 25 mg 1 tab by mouth daily, -senna (for constipation) 8.6 mg 1 tabs by mouth twice daily, -sodium bicarbonate (antacid) 325 mg 1/2 tablet	01820		

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01820	Continued From page 9 by mouth in morning and 1/2 tablet in the evening, -clonidine (for blood pressure) 0.3 mg 1 patch to skin weekly, -lantus (long acting insulin for diabetes) 10 units (u) under the skin at bedtime, -acetaminophen 2 tabs three times daily, as needed for pain or fever, and -polyethylene glycol (for constipation) mix with 8 ounces of fluids, take by mouth daily. R2 R2's service plan dated June 4, 2025, indicated R2 received services to include assistance with medication administration, three times daily. On September 10, 2025, at 11:40 a.m., the surveyor observed unlicensed personnel (ULP)-B assist R2 with medication administration. R2's MAR for September 2025 indicated R2 was scheduled to take the following medications: -linagliptin (for diabetes) 1 tablet of Tradjenta (lingliptin) (5mg) by mouth every morning before breakfast, -aspirin 81 mg 1 tablet by mouth every morning, -clopidogrel 75 mg 1 tablet every day, -docusate sodium - sennosides (for constipation) 50 mg-8.6 mg 1 tablet by mouth twice daily, -Jardiance (for diabetes) 10 mg 1 tablet by mouth once daily, -multivitamin/multimineral supplement 1 tablet by mouth daily, -fluticasone (for sinus irritation) 50 micrograms (mcg) instill 2 sprays into EACH nare once daily, -acetaminophen 1 tab by mouth every 8 hrs as needed for pain or fever.	01820		

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01820	Continued From page 10 R1 and R2's records lacked current signed provider orders for the above-listed medications. On September 10, 2025, at 2:50 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they used the list of residents' current medications on the after-visit summary (AVS) they received after medical appointments as the orders. LALD/CNS-A stated the AVS did not have a manual signature or electronic signature. The licensee's medication and treatment orders policy, undated, indicated the RN is responsible for assuring that current, authorized prescriber orders for medications or treatments administered by the staff are kept on file in the residents' records. The policy further indicated an order for medication or treatment must contain the name of the resident,a description of the medication, treatment, or therapy to be provided and the frequency, duration, and other information needed to carry out the order. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be	01970		

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01970	Continued From page 11 renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure up-to-date signed treatment or therapy orders were maintained for one of one resident with treatments (R2). 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 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: R2's service plan dated June 4, 2025, indicated R2 received services to include monitoring blood glucose level daily. On September 10, 2025, at 11:40 a.m., unlicensed personnel (ULP)-B stated she read R2's blood glucose level by scanning the continuous blood glucose monitor. ULP-B entered the value into the resident record and used the value to determine R2's insulin dosage. R2's Individualized Treatment and Therapy Plan dated September 10, 2025, indicated the ULP should record blood sugar daily. The plan further indicated the registered nurse would supervise by observing the ULP "obtain blood sugar as order by MD".	01970		

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01970	Continued From page 12 R2's record lacked a signed provider order directing the frequency of blood sugar monitoring and parameters. On September 10, 2025, at 2:50 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they used the list of residents' current medications on the after-visit summary (AVS) they received after medical appointments as the orders. LALD/CNS-A stated the AVS did not have a manual signature or electronic signature. LALD/CNS-A stated that would also be the case for treatment orders. The licensee's medication and treatment orders policy, undated, indicated the RN is responsible for assuring that current, authorized prescriber orders for medications or treatments administered by the staff are kept on file in the residents' records. The policy further indicated an order for medication or treatment must contain the name of the resident,a description of the medication, treatment, or therapy to be provided and the frequency, duration, and other information needed to carry out the order. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		

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

MINNEHAHA CARE
1477 MINNEHAHA AVE E
St Paul, MN 55106
Ramsey County
Parcel:

Phone:

License Info

License: HFID 41394

Risk:
License:
Expires on:
CFPM: CHU XIONG
CFPM #: 107183; Exp: 7/22/2027

Inspection Info

Report Number: F8058251103
Inspection Type: Full - Single
Date: 9/8/2025 Time: 1:23:13 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

HRD INSPECTOR ROBYN WOOLLEY

41 BEEF COOLER
40 YOGURT COOLER
180 RICE WARMER
41 TOMATO COOLER
40 STRAWBERRY COOLER

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 F8058251103 from 9/8/2025

CHU XIONG
DIRECTOR

Aaron Gertz,
Public Health Sanitarian 3
651-201-4516
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