Electronically Delivered

July 17, 2026

Licensee
Shephards Home LLC
8381 Yearling Drive
Woodbury, MN 55129

RE: Project Number(s) SL40300015

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 June 10, 2026, 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 . . ."

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 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - $500.00

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
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

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.

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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40300	A. BUILDING: _____ B. WING _____	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEPHERDS HOME LLC	8381 YEARLING DRIVE WOODBURY, MN 55129

(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: SL40300015-0 On June 8, 2026, through June 10, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were three residents; three 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.	
0 480 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 June 9, 2026, 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=D	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 and interview, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control. The licensee failed to ensure direct care staff performed adequate hand hygiene (HH) for one of two employees (unlicensed personnel (ULP)-E). 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).	0 510		

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0 510	Continued From page 4 The findings include: ULP-E was hired September 10, 2025, and provided direct care for residents. On January 8, 2026, during a continuous observation from 12:02 p.m., through 12:16 p.m., the surveyor observed owner/registered nurse (O/RN)-C and ULP-E assist R2 with personal cares, including incontinence cares and a mechanical ceiling lift transfer from wheelchair to bed and back. ULP-E and O/RN-C donned gloves after completing HH with soap and water. ULP-E and O/RN-C assisted R2 from her wheelchair to the bed using a mechanical ceiling lift. R2 was lying supine in bed and both ULP-E and O/RN-C assisted R2 with peri-cares and changing R2's incontinence brief. After completing peri-cares and changing R2's incontinence brief, without first removing gloves and performing HH, ULP-E retrieved R2's sling for the ceiling lift and, along with O/RN-C, assisted R2 with a mechanical ceiling lift transfer back into the wheelchair. Next, ULP-E removed the soiled gloves and, without first performing HH, grasped the handles on R2's wheelchair and assisted R2 into the kitchen area. The surveyor then observed ULP-E touched R2's hand and her iPad. Finally, ULP-E completed HH at the kitchen sink using soap and water. On June 8, 2026, at 12:16 p.m., ULP-E stated he received infection control training from the nurse, upon hire. On June 8, 2026, at 12:18 p.m., O/RN-C stated staff were trained during orientation and annual training to wash their hands. O/RN-C stated ULP-E should have completed hand hygiene and glove change after assisting R2 with peri-cares	0 510		

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0 510	Continued From page 5 and changing the incontinence brief. The Centers for Disease Control and Prevention (CDC) guidance, CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, revised November 29, 2022, indicated standard precautions were to be used to care for all patients in all settings to include HH, and noted, "Use an alcohol-based hand rub or wash with soap and water for the following clinical indications: a. Immediately before touching a patient b. Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices c. Before moving from work on a soiled body site to a clean body site on the same patient d. After touching a patient or the patient's immediate environment e. After contact with blood, body fluids or contaminated surfaces f. Immediately after glove removal." The licensee's Infection Control policy, dated March 28, 2025, indicated "[Licensee] will observe the recommended precautions for assisted living as identified by the Centers for Disease Control and Prevention (CDC). The precautions cover those residents with documented or suspected infection with highly transmissible or epidemiologically important pathogens that require additional precautions to prevent transmission. The practice of employees will conform with OSHA regulations, current law and currently accepted health care, medical and nursing standards of practice for infection control." In addition, included, "Handwashing 3. Hands should be washed at the following times.	0 510		

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0 510	Continued From page 6 a. After changing beds b. Before assisting with medications c. Before and after treatments d. After all pet care e. After housekeeping f. After emptying bedpans g. After assisting the resident to the toilet h. After removing items from the floor i. Before preparing food j. Before feeding residents k. After using the bathroom l. After coughing or sneezing m. After smoking n. After handling plants o. After removing gloves." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents.	0 680		

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0 680	Continued From page 7 (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents receiving services under the assisted living license. 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: The licensee's emergency disaster preparedness plan, updated July 24, 2025, lacked evidence of the following required content: -arrangement with other facilities and transportation during an emergency evacuation; and -documentation of review of missing resident policy quarterly.	0 680		

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0 680	Continued From page 8 On June 9, 2026, at 10:12 a.m., chief operating officer (COO)-D stated they had not completed evacuation or transportation agreements yet but had plans to complete the requirement. COO-D verbalized the licensee had not yet completed or documented the missing resident policy reviewed quarterly. Education provided. The licensee's Emergency Preparedness policy dated March 28, 2025, indicated "[Licensee] will have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. The plan considers the organization's commitment to provide services while ensuring the safety of its employees and residents. [Licensee] will implement the Emergency Management program as soon as the agency becomes aware of the existence of an emergency." The licensee's Missing Resident policy dated March 28, 2025, indicated, "11. The missing resident procedure will be reviewed by the Director and Clinical Nurse Supervisor at least quarterly. Changes to the plan will be documented." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 790 SS=C	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code;	0 790		

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0 790	Continued From page 9 (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. 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 the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated June 9 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		

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0 810	Continued From page 10	0 810		
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. (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	0 810		

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0 810	Continued From page 11 review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated June 9 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty one (21) days	0 810		
01420 SS=E	144G.62 Subd. 2 Delegation of assisted living services (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If the unlicensed personnel has not regularly performed the delegated assisted living task for a period of	01420		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40300	A. BUILDING: _____ B. WING _____	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEPHERDS HOME LLC	8381 YEARLING DRIVE WOODBURY, MN 55129

(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
01420	Continued From page 12 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, licensee failed to provide clear instructions by a registered nurse (RN) to unlicensed personnel (ULP) for delegated full body mechanical lifts for two of three 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 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 found to be pervasive). The findings include: R1 R1 had diagnoses including hydrocephalus (extra fluid in brain), weakness, and legally blind. R1's Service Plan dated February 20, 2026, indicated R2 received services including assistance with housekeeping, laundry, personal cares, toileting, bathing, transfers with mobility assistance, and medication administration. R1's most recent comprehensive assessment	01420		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40300	A. BUILDING: _____ B. WING _____	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEPHERDS HOME LLC	8381 YEARLING DRIVE WOODBURY, MN 55129

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01420	Continued From page 13 dated May 11, 2026, indicated, "Mobility - Transfer, Needs an assistive device to transfer: Sit-to-stand lift, Up to 2 assist for mech assisted sit-to-stand transfer. 5/11/26: Has an electric Hoyer lift." R1's Individual Abuse Prevention Plan dated May 11, 2026, indicated, "Mobility - Ambulation, Unable to ambulate, Resident [lower left extremity] weakness has not allowed for safe ambulation. Resident uses [wheelchair] escort for in-home transport and stand lift for all transfers." On June 9, 2026, during continuous observation from 8:51 a.m. to 9:33 a.m., the surveyor observed ULP-H and owner/registered nurse (O/RN)-C assist R1 with personal care and a mechanical lift transfer using a Hoyer lift from R1's bed to wheelchair. R2 R2 had diagnoses including fracture of left femoral neck (upper thigh bone) with history of hip hemiarthroplasty (partial hip replacement), developmental delays, and seizure disorder. R2's Service Plan dated February 20, 2026, indicated R2 received services including assistance with housekeeping, laundry, personal cares, toileting, bathing, transfers with mobility assistance, tube feeding, and medication administration. R2's most recent comprehensive assessment dated May 18, 2026, indicated, "Mobility - Transfer, Needs assistance with transferring, specify: Client's balance and gait unsteady. [R2] reports leg weakness and bilateral knee pain, more on the right. Requires 1 to 2 person assist with in-room CEILING lift transfers for safety."	01420		

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	40300	A. BUILDING: _____ B. WING _____	06/10/2026

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01420	Continued From page 14 Also, included, "Needs an assistive device to transfer: Hoyer lift in-room CEILING LIFT." On June 8, 2026, during continuous observation from 12:02 p.m. to 12:16 p.m., the surveyor observed O/RN-C and ULP-E assist R2 with personal cares. On June 8, 2026, at 12:18 p.m., ULP-E stated he was trained by the nurse to transfer R1 and R2 independently using the Hoyer mechanical lift and mechanical ceiling lift. ULP-E verbalized he would update the nurse right away if there were any concerns that came up with the resident transfers. R1 and R2's medical records lacked clear parameters and instructions by the nurse for when one or two employees would be required to safely complete R1's Hoyer mechanical lift transfer or R2's ceiling lift transfer. On June 8, 2026, at 12:50 p.m., clinical nurse supervisor (CNS)-B stated he thought there should be two employees here to assist with R1 and R2's mechanical lift transfers. CNS-B verbalized on day shift there typically were two employees here to assist with cares but there was usually only one person on evening and night shift. On June 8, 2026, at 2:27 p.m., O/RN-C stated all employees were trained and skill competency completed to use R1's Hoyer mechanical lift and R2's mechanical ceiling lift using one person. O/RN-C stated the nurse assessed the needs of R1 and R2 to be safe with the number of staff to be used for each transfer. O/RN-A agreed the assessment needed to be clear on whether one or two employees were required to safely transfer	01420		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40300	A. BUILDING: _____ B. WING _____	06/10/2026

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01420	Continued From page 15 R1 and R2. O/RN-A planned to update the assessment and instructions for the ULP's based on the assessments for both R1 and R2. The licensee's Delegation of Assisted Living Tasks policy dated March 28, 2025, indicated, "1. A clinician will complete an assessment of all residents receiving delegated services prior to the initiation of those services*. 2. The assessment will evaluate the resident's functional status and need for assisted living services and includes a vulnerable adult assessment. 3. Following the assessment, the clinician will develop the Care Plan that specifies the activities to be completed by the assisted living staff and addresses the areas of vulnerability identified in the assessment. 4. The Care Plan is prepared with the resident or responsible party and incorporates the resident's needs and preferences. 5. The Assessment and Care Plan are parts of the resident's clinical record**.6. The clinician may delegate procedures according to the following a. The clinician instructed the home health aide in the proper methods to perform the procedure with respect to each resident. b. The clinician provided the home health aide with written instructions specific to the resident. c. The home health aide demonstrated to the clinician competence in the procedure. d. The procedure is documented in the resident's clinical record. e. The home health aide's competence is documented in his/her personnel file." The licensee's Staffing policy dated March 28, 2025, indicated, "At least two (2) home health aides will be scheduled and available for residents requiring the assistance of two home health aides for scheduled and reasonably foreseeable unscheduled needs as reflected in	01420		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01420	Continued From page 16 the assessment and service plan." The licensee's Mechanical Lift policy dated 2016, indicated, "Review the Care Plan for procedure." The manufacturer directions for Bestcare full body patient lift, dated 2013, indicated on page 18, "Do not attempt to transfer a patient without prior approval of the person's nurse. Also, do not transfer without having studied the instructions and performed several practices in operating the product. Together (with the patients doctor, nurse, or medical attendant) select a sling that is both practical and comfortable. The sling selected should be one that serves the needs of the patient, while providing the patient with optimal safety. Never interfere with the lift, unless instructed by the attendant. Have a doctor, nurse, or medical attendant (experienced in the use of the BestLift) present during the first few times the lift is used to transfer a new user." The manufacturer directions for Maxi Sky 2 ceiling lift, dated September 2019, indicated on page 15, "Actions Before Every Use, NOTE: The need for a second attendant to support the patient must be assessed in each individual case." Also, included, "WARNING: Before an attempt is made to move a patient, a clinical assessment of the patient's suitability for transfer must be carried out by a qualified health professional considering that, among other things, the transfer may induce substantial pressure on the patient's body. A transfer conducted when it should not can degrade the patient's health condition." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	01420		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40300	A. BUILDING: _____ B. WING _____	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEPHERDS HOME LLC	8381 YEARLING DRIVE WOODBURY, MN 55129

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01420	Continued From page 17 (21) days	01420		

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

Shepherds Way Home
8381 YEARLING DRIVE
Woodbury, MN 55129
Washington County
Parcel:

Phone:
lois.gross@hatcch.org

License Info

License: HFID 40300

Risk:
License:
Expires on:
CFPM: Berniell Jardio
CFPM #: 118132; Exp: 7/15/2026

Inspection Info

Report Number: F1031261192
Inspection Type: Full - Single
Date: 6/9/2026 Time: 11am
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 1
Total Priority 2 Orders: 3
Total Priority 3 Orders: 1
Delivery: Emailed

! **New Order: 2-200 Employee Health**
2-201.11C *Priority Level: Priority 1 CFP#: 3*
MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.
COMMENT:
ESTABLISHMENT HAS ILLNESS LOG, BUT NOT FILLING OUT SYMPTOMS.
DISCUSSED HOW TO FILL OUT LOG WITH PIC.
FILL OUT ALL AREAS OF ILLNESS LOG WHEN ILLNESS OCCURS.

Comply By: 6/9/2026 Originally Issued On: 6/9/2026

New Order: 4-300 Equipment Numbers and Capacities
4-302.12B *Priority Level: Priority 2 CFP#: 36*
MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.
COMMENT:
ESTABLISHMENT DOES NOT HAVE A THIN PROBE THERMOMETER.

Comply By: 6/12/2026 Originally Issued On: 6/9/2026

New Order: 4-300 Equipment Numbers and Capacities
4-302.14 *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.
COMMENT:
ESTABLISHMENT DOES NOT HAVE SANITIZER TESTING KIT ON SITE.
PURCHASE KIT AND TEST SANI CONCENTRATION (50-200PPM BLEACH, 150-400PPM QUAT) ON REGULAR BASIS.

Comply By: 6/12/2026 Originally Issued On: 6/9/2026

New Order: 4-500 Equipment Maintenance and Operation
4-501.11AB *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.
COMMENT:
LIGHTS ABOVE RANGE ARE NOT WORKING.
REPLACE/REPAIR LIGHTS.

Comply By: 6/30/2026 Originally Issued On: 6/9/2026

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control
6-501.115AB *Priority Level: Priority 2 CFP#: 38*
MN Rule 4626.1585AB Remove all live animals from the establishment except as specified in rule.
COMMENT:
DOG ALLOWED TO PASS THROUGH KITCHEN AREA.
PREVENT DOG FROM ENTERING KITCHEN AREA BY BARRIER OR OTHER METHOD.

Comply By: 6/12/2026 Originally Issued On: 6/9/2026

Food & Beverage General Comment

Nurse Evaluator on site: Dede Hinnendael

All violations discussed with PIC during the inspection.

NOTES:
Facility has a residential kitchen with the following finishes:
Laminate wood flooring
Wood cabinetry
Stone countertops
Flat, Painted ceiling
2-comp sink with left basin designated for handwashing.

Since establishment has a residential kitchen (4626.0506(G)(2)) Same-day service only. No saving and reheating of foods or preparation of foods the day prior to eating. Any remaining food from meals to be removed/discarded at end of day.

Discussed the following with pic:
Hand washing
Ware washing and dish machine temp (160F or greater)
Illness and illness log
No undercooked foods and cooking temps
Pasteurized egg use

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 F1031261192 from 6/9/2026

Lois Gross
Person in Charge

Chris Foster, REHS/RS
Public Health Sanitarian 3
651-201-4728
chris.j.foster@state.mn.us

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

Temperature Observations/Recordings

Establishment Info

Shepherds Way Home
Woodbury
County/Group: Washington County

Inspection Info

Report Number: F1031261192
Inspection Type: Full
Date: 6/9/2026
Time: 11am

Food Temperature: Product/Item/Unit: Milk**; Temperature Process:** Cold-Holding
Location: Refrigerator at 41 Degrees F.
Comment:
Violation Issued?: No

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

Sanitizer Observations/Recordings

Establishment Info

Shepherds Way Home
Woodbury
County/Group: Washington County

Inspection Info

Report Number: F1031261192
Inspection Type: Full
Date: 6/9/2026
Time: 11am

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Kitchen **Equal To** 160.1 Degrees F.
Comment:
Violation Issued?: No

Sanitizing Chemical: **Product:** Purell NSF Approved Sanitizer**; Sanitizing Process:** Wiping Cloth Bucket
Location: Kitchen **Equal To** PPM
Comment:
Violation Issued?: No

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL40300015-0	**Date:** 6/9/2026
Facility Name: Shepherds Way Home	
Facility Address: 8381 Yearling Dr, Woodbury, Mn 55129	

☒ **TAG IDENTIFICATION: 0790**

SCOPE/ SEVERITY: Level 1; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

1. Portable fire extinguishers installed and maintained to MN State Fire Code. [Minn. Stat. 144G.45 subd.2]

   Comments: Upon inspection of the fire extinguishers two of the four were found to have a 2022 manufacture date and did not have current annual inspection tags.

☒ **TAG IDENTIFICATION: 0810**

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

1. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that are readily available at all times within the facility. [Minn. Stat. 144G.45 subd.2]

   Comments: The FSEP did not include any specific procedures for evacuation that were relevant to the facility. The provided documentation included general fire safety tips.

2. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include employee actions to be taken in the event of a fire or similar emergency. [Minn. Stat. 144G.45 subd.2]

   Comments: The FSEP did not include any specific staff actions, only general evacuation information.

3. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include fire protection procedures necessary for residents. [Minn. Stat. 144G.45 subd.2]

   Comments: The FSEP did not include any specific resident actions, only general evacuation information.