



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 2, 2026

Licensee

Ayan Care Inc

1224 Vista Drive

Burnsville, MN 55337

RE: Project Number(s) SL39895016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 10, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;

Level 3: a fine of \$1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 4: a fine of \$3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

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

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

pursuant to this survey:

St - 0 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - \$500.00

St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - \$1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$1,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

REQUESTING A HEARING

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

To submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: <https://forms.office.com/g/Bm5uQEPhVa>. Your input is important to us and will enable MDH to improve its processes and communication with providers.

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in black ink, appearing to read "Jodi Johnson", with a long horizontal flourish extending to the right.

Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39895	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/10/2026
NAME OF PROVIDER OR SUPPLIER AYAN CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1224 VISTA DRIVE BURNSVILLE, MN 55337		
(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: SL39895016-0 On September 8, 2026, through September 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 resident(s); three receiving services under the Assisted Living Facility license. 2310: An immediate order was issued on September 9, 2026, at a level 3, Isolated (G). The licensee took immediate action; however, 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 oMinnesota Department of Health is documenting the State Correction Orders using federal software. Tag ut of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. 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.		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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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) 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, Food and Beverage Establishment Inspection Report (FBEIR) dated September 8, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee	0 480			

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0 480	Continued From page 3 within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 650 SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one employee record (unlicensed personnel (ULP)-C) contained a performance evaluation that identified areas of improvement needed and	0 650			

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0 650	Continued From page 4 training needs. 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: ULP-C was hired on May 1, 2023, to provide direct care to residents at the assisted living facility. On September 8, 2026, at 2:00 p.m., the surveyor observed ULP-C administering medications to R4. ULP-C's employee record lacked evidence of a completed performance evaluation that identified areas of improvement needed and training needs. On September 9, 2026, at 2:30 p.m., licensed assisted living director (LALD)-A stated he was not sure whose responsibility it was to complete a performance evaluation. LALD-A stated he did not complete one but will check with RN-B. LALD-A later proved a copy of the staff supervision summary for ULP-C and stated that was all they had. The staff supervision summary indicated ULP-C was observed during medication administration on September 17, 2025. The licensee's Performance Evaluation Policy dated May 17, 2023, indicated All paid employees, individual contractors and regularly	0 650			

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0 650	Continued From page 5 scheduled volunteers providing assisted living services will participate in an annual performance evaluation. The purpose of the evaluation is to measure job performance and assist the employee and supervisor to build on the strengths of the employee and identify those areas needing improvement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the provider established and maintained a tuberculosis (TB) prevention program based on the most current guidelines	0 660			

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0 660	Continued From page 6 issued by the Centers for Disease Control and Prevention (CDC) which included completion of a facility risk assessment annually. 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 the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on September 8, 2026, at 9:45 a.m., the surveyor asked for the licensee's TB risk assessment and licensed assisted living director (LALD)-A stated he was in charge of the facility TB risk assessment and completed it over a year ago. LALD-A stated he is aware that it is required annually and is not always good and remembering to complete it regularly. LALD-A provided their latest Facility TB Risk Assessment dated April 25, 2024, and later provided a new Facility TB risk assessment dated September 8, 2026, after the survey had started. The licensee's Tuberculosis Screening/Prevention Policy dated May 17, 2023, indicated The Director is responsible for conducting the TB Risk Assessment annually using the MDH Risk assessment worksheet to determine the OSHA TB risk associated with the agency's population. Included in the risk assessment are the incidence of reported TB cases in the counties where service is provided, the number of confirmed agency clients with	0 660			

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0 660	Continued From page 7 active TB within the past 5 years and the conversion rate if applicable. The MN Department of Health Facility Tuberculosis (TB) Risk Assessment Instructions and Worksheet for Health Care Setting Licensed by MDH updated June 2023, indicated: Settings should perform a facility risk assessment on an annual basis. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 660			
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans;	0 730			

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0 730	Continued From page 8 (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of one resident record (R1) included a discharge summary as required. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic	0 730			

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0 730	Continued From page 9 failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's Discharge Resident/Client Roster dated May 5, 2026, indicated R1 was admitted with a diagnosis of bipolar disorder, shortness of breath, and post-traumatic stress disorder on August 31, 2025, and discharged on April 30, 2026, to another facility. R1's service plan dated September 5, 2025, indicated R1 received the following services: medication administration, dressing, and grooming. R1's discharge care plan dated May 1, 2026, did not include documentation of the discharge. R1's resident notes dated January 1, 2026, through September 9. 2026, had a last entry date of April 2, 2026, and did not include any information of R1's discharge on April 30, 2026. R1's record failed to include a discharge summary that includes a service termination notice and related documentation, as required. On September 9, 2026, at 12:45 p.m., licensed assisted living director (LALD)-A stated he was unaware of the requirements for a summary at the time of discharge. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 730			

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0 780	Continued From page 10	0 780			
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; 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.	0 780			

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0 780	Continued From page 11 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 September 9, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) Days.	0 780			
0 790 SS=F	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; (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:	0 790			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39895	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/10/2026
NAME OF PROVIDER OR SUPPLIER AYAN CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1224 VISTA DRIVE BURNSVILLE, MN 55337			
(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
0 790	Continued From page 12 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 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 September 9, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790			
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and	01500			

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01500	Continued From page 13 staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or	01500			

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01500	Continued From page 14 (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of one employee (unlicensed personnel (ULP)-C). 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 the residents). The findings include: ULP-C was hired on May 1, 2023, to provide direct care to residents at the assisted living facility. On September 8, 2026, at 2:00 p.m., the surveyor observed ULP-C administering medications to R4. ULP-C's employee record lacked evidence of successfully completed annual training as required in the following area: * Training on reporting of maltreatment of vulnerable adults under section 626.557;	01500			

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01500	Continued From page 15 * Review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights. On September 9, 2026, at 2:30 p.m., licensed assisted living director (LALD)-A stated he thought annual training was just dementia and mental health training and has not assigned any employees the training for reporting of maltreatment of vulnerable adults under section 626.557, or the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights. The licensee's Staff Orientation and Education Policy dated May 17, 2023, indicated all staff providing assisted living services will complete at least eight (8) hours of education for every twelve (12) months of employment. Education topics will include, but not be limited to, the following: a. Reporting of maltreatment of adults b. Review of Assisted Living Bill of Rights and staff responsibilities related to ensuring the exercise and protection of those rights No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500			
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced	01880			

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01880	Continued From page 16 by: Based on observation, interview, and record review the licensee failed to ensure all medications were securely locked in substantially constructed compartments and permitted only authorized personnel had access. This had the potential to affect the licensee's current 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 the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on September 8, 2026, at 9:45 a.m., licensed assisted living director (LALD)-A and registered nurse (RN)-B indicated the licensee provided medication management to all three residents, and that all medications were securely stored in a locked medication closet located in the hallway on main floor. ULP-C was hired on May 1, 2023, to provide direct care to residents at the assisted living facility. On September 8, 2026, at 11:00 a.m., the medication closet was reviewed with LALD-A and found to be locked. On September 8, 2026, at 2:00 p.m., the surveyor observed ULP-C looking for the medication keys to administer medications to R4. ULP-C stated	01880			

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01880	Continued From page 17 that she keeps the keys in her pocket and unlocks it only when needing to get medications. ULP-C asked LALD-A if he had the keys. The keys were found hanging from the doorknob of the medication closet. LALD-A stated "we usually always keep the medication closet door locked and one of us always keeps the key on us at all times." LALD-A further stated the keys should not be left in the door. The licensee's Storage/Control of Medications policy dated May 17, 2023, indicated all prescription drugs are securely locked in substantially constructed compartments according to the manufacturer's directions. Only authorized personnel have access to the stored medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances.	01910			

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01910	Continued From page 18 (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed upon discharge, to document in the resident's record the disposition of the medication including the required information for one of one discharged resident (R1). 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: R1 started receiving services on August 31, 2025, and was discharged to another facility on September 1, 2026. R1's service plan effective September 5, 2025, indicated she received assistance with dressing, grooming, and medication administration. R1's current medication list dated May 1, 2026, indicated R1 was taking the following medications: Aripiprazole 2 milligrams (mg) one time a day for mood/depression	01910			

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01910	Continued From page 19 Buspirone 10 mg daily for anxiety Divalproex Sodium 500 mg for migraines Eliquis 5 mg for irregular heart rhythm R1's discharge care plan dated May 1, 2026, listed allergies, diagnosis, medications and dosage but failed to indicate the prescription (RX) number, and the quantity. The form lacked names of staff or other individuals involved in disposition of the medication. R1's record contained a note section with entries on admission, and behaviors. Last recorded note was on April 2, 2026. (152 days prior to discharge). R1's record failed to provide any discharge summary indicating that the resident was discharging and their condition at discharge. On September 9, 2026, at 12:45 p.m. licensed assisted living director (LALD)-A stated he was unaware of the requirements for discharge medications and the need for RX numbers or a signature. LALD-A stated he has ability to add RX numbers in his medication software but has never done that. The licensee's Disposition and Disposal of Medications policy dated May 17, 2023, indicated Upon disposition, the licensee, will document the following information in the clinical record a. Name, strength and prescription number of medication, as applicable b. Quantity c. Method of disposition or to whom the medications were given d. Date of disposition e. Name(s)/signature(s) of staff or other individuals involved in disposition f. If applicable, to whom the medications were given	01910			

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01910	Continued From page 20 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910			
02310 SS=G	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 care and services were provided according to acceptable health care and medical or nursing standards for one of one resident with side rails (R4). This resulted in an immediate correction order on September 9, 2026. 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 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 September 8, 2026, at 10:30 a.m. during the facility tour with licensed assisted living director	02310	During the survey, the licensee took appropriate action to address the immediate risk to the resident.		

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02310	Continued From page 21 (LALD)-A and registered nurse (RN)-B the surveyor observed R4's bed was a hospital bed with bilateral side rails. One side rail was in the up position against the wall, and the other one was in the down position. RN-B stated R4 does use the siderails at night and demonstrated how they put both siderails in the up position and use a pillow alongside the siderail in the up position. RN-B stated R4 liked to hang her leg over the side rail, so they used the pillow alongside the length of the side rail. LALD-A stated R4 did not have a hospital bed with side rails when she was admitted, but during an assessment RN-B had identified a need and they worked on getting one for her. R4 began receiving services on May 12, 2024, under the licensee's assisted living facility license. R4's diagnoses included anxiety, major depressive disorder, and Lewy Body Dementia. R4's undated Care Plan indicated she received services to include assistance with medication administration, dressing, bathing, mobility, feeding, and transfers. R4's comprehensive assessments dated August 24, 2026, May 24, 2026, February 24, 2026, and November 24, 2025, under Equipment used, lacked indication a hospital bed with siderails was in use. R4's medical record lacked evidence that a siderail assessment with measurements and a risk verses benefits use of siderails was completed. On September 9, 2026, at 10:30 a.m. RN-B	02310			

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02310	Continued From page 22 stated R4 received the hospital bed with siderails about one to two months ago and he had not completed a bedrail assessment or reviewed with R4's spouse the risk vs. benefits of side rail use. RN-B was unaware of the requirements. On September 9, 2026, at 9:00 a.m. R4 was observed lying in bed with bilateral full length side rails in the up position. Unlicensed personnel (ULP)-C was observed to assist R4 in transferring from a lying to sitting position on the side of the bed after lowering one side rail. The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (space between the rails), should be less than four and three quarters' inches. The Food and Drug Administration (FDA), "A Guide to Bed Safety," revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The Minnesota Department of Health website Assisted Living FAQs for Hospital-Style bedrails, dated April 17, 2026, indicated, "Best practice for documentation about a resident's bed rails includes, but is not limited to: Purpose and intention of the bed rail Measurements	02310			

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02310	Continued From page 23 The resident's bed rail use/need assessment Risk vs. benefits discussion (individualized to each resident's risks) The resident's preferences Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements." The licensee's Side Rail Use policy, dated May 17, 2023, indicated before implementing side rails for a resident, the RN will conduct a side rail assessment and the RN will discuss with the resident/resident's representative alternative to the use of side rails and the resident/resident's representative will co-sign the document agreeing to the benefits and risks of the side rails. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate The licensee took immediate action to mitigate risk on September 9, 2026; however, the scope and level will remain at G.	02310			
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision.	03090			

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03090	Continued From page 24 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure signage was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all residents, staff, and visitors of the licensee. 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 potential to affect a large portion or all the residents). The findings include: On September 8, 2026, at 11:00 a.m. during the facility tour with licensed assisted living director (LALD)-A and registered nurse (RN)-B, the surveyor did not observe the required electronic monitoring sign that reads, "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." LALD-A stated it used to be posted on the front door and the bulletin board; however, he thought it was no longer needed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090			



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

Page: 1

Establishment Info

AYAN CARE INC
1224 VISTA DRIVE
Burnsville, MN 55337
Dakota County
Parcel:

Phone:

License Info

License: HFID 39895

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

Inspection Info

Report Number: F1018261142
Inspection Type: Full - Single
Date: 9/8/2026 Time: 8:41:42 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 1
Total Priority 2 Orders: 0
Total Priority 3 Orders: 1
Delivery:

New Order: 2-100 Supervision

2-102.12AMN Priority Level: Priority 3 CFP#: 2

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

COMMENT: No certified food protection manager on site. Staff claim to have the certificate, but no records could be found to support the claim. CFPM resources sent with report.

Comply By: 9/8/2026 Originally Issued On: 9/8/2026

! 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 is not currently keeping an illness log to record instances of illness in employees. Illness log sent with report.

Comply By: 9/8/2026 Originally Issued On: 9/8/2026

Food & Beverage General Comment

Establishment is a residential home with residential equipment and finishes.

Establishment does all same day service of foods. No leftovers are saved for use the next day.

Dishwasher has sanitize function available and test strip indicated appropriate temperature was achieved.

Kitchen has separate sinks for hand washing and food prep.

Walls are painted, ceiling is painted, and floors are tile.

Cabinets are wooden and countertops are laminate.

Discussed employee illness and pest control services.

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 F1018261142 from 9/8/2026



Jamal Turvie
Manager

Rebecca Prestwood, REHS
Public Health Sanitarian 3
651-201-3777
rebecca.prestwood@state.mn.us



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

Temperature Observations/Recordings

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Establishment Info

AYAN CARE INC
Burnsville
County/Group: Dakota County

Inspection Info

Report Number: F1018261142
Inspection Type: Full
Date: 9/8/2026
Time: 8:41:42 AM

Food Temperature: **Product/Item/Unit:** sour cream; **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

Page: 1

Establishment Info

AYAN CARE INC
Burnsville
County/Group: Dakota County

Inspection Info

Report Number: F1018261142
Inspection Type: Full
Date: 9/8/2026
Time: 8:41:42 AM

Sanitizing Equipment: Product: Hot Water; **Sanitizing Process:** Dish Machine

Location: Kitchen **Equal To** 160 Degrees F.

Comment:

Violation Issued?: No

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL39895016-0	Date: 9/9/2026
Facility Name: Ayan Care Inc	
Facility Address: 1224 Vista Drive, Burnsville, MN 55337	

☒ TAG IDENTIFICATION: 0780

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

1. Smoke alarms are provided in each room used for sleeping purposes. [Minn. Stat. 144G.45 subd.2]

Comments: The hardwired smoke alarms were missing in the lower-level sleeping room, computer room and the mechanical room.

☒ TAG IDENTIFICATION: 0790

SCOPE/ SEVERITY: Level 2; 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: The annual service was not completed on all fire extinguishers in the facility.