DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF INITIAL LICENSE DENIAL

Electronically Delivered

May 28, 2026

Licensee
Eden Homes & Care Services LLC
18741 Ivanhoe Street Northwest
Elk River, MN 55330

RE: Denial of License Number 421488
Health Facility Identification Number (HFID) 42027
Initial Survey; Project Number(s) SL42027015

Dear Licensee:

The Minnesota Department of Health (MDH) completed an initial survey on February 20, 2026 for the purpose of assessing compliance with state licensing statutes and determine issuance of an initial license to the above-mentioned provider. Based on the survey, MDH found you not in substantial compliance with the laws pursuant to Minnesota Statute, Chapter 144G. As a result, your authority to continue to operate under a provisional license or be approved for an assisted living facility license is being denied.

INELIGIBILE LICENSURE TIMELINE

Pursuant to Minn. Stat. § 144G.16, subd. 3 (c), the owners and managerial officials of a provisional licensee whose license is denied are ineligible to apply for an assisted living facility license under this chapter for one (1) year following the facility's closure date.

STATE CORRECTION ORDERS

The enclosed State Form documents the state licensing orders. The Department of Health documents state 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 . . ."

REQUEST FOR RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.16, Subd. 4, you may request a reconsideration by the Minnesota Department of Health. The request for reconsideration process must be conducted internally by the Minnesota Department of Health and Chapter 14 does not apply. **This is your only ability to request a reconsideration under this enforcement action.**

To submit a reconsideration request, please visit:

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

Note requests for reconsideration must be received by the department within 15 calendar days of the date of this notice.

REQUIREMENTS FOR NOTIFICATION AND TRANSFER OF RESIDENTS
You must comply with the requirements for notification and coordinated move of residents noted in Minn. Stat. § 144G.52 and Minn. Stat. § 144G55. Additionally, please provide the information described in Minn. Stat. § 144G.20, Subd. 15 (a) (1), (2), (3), (4) and (5) to this department's contact, Kelly Thorson, via email at: Kelly.Thorson@state.mn.us. Also provide this information to the lead agencies as defined in section 256B.0911, county adult protection and case managers, and the ombudsman for long-term care no later than **06/02/2026**.

Pursuant to Minn. Stat. § 144G.16, Subd. 5 (3), a provisional licensee whose license is denied is permitted to continue operating as an assisted living facility during the period of time when a transfer of assisted living facility resident(s) from the provisional licensee to a new assisted living facility provider is in process.

Additionally, pursuant to Minn. Stat. § 144G.16, Subd. 5 (1), you may continue operating during the reconsideration process.

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

If you have any additional questions, please do not hesitate to contact Kelly Thorson, Supervisor, at Kelly.Thorson@state.mn.us. Kelly Thorson can also be reached by office phone at 320-223-7336.

Sincerely,

Rick Michals, J.D.
Executive Regional Operations Manager
Minnesota Department of Health
Health Regulation Division

KKM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	42027	A. BUILDING: _____ B. WING _____	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDEN HOMES & CARE SERVICES LLC	18741 IVANHOE ST NW ELK RIVER, MN 55330

(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: SL42027015-0 On February 17, 2026, through February 23, 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 two residents; two receiving services under the Provisional Assisted Living Facility license. An immediate correction order was identified on February 18, 2026, issued for SL42027015-0, tag identification 1290. During the course of the survey, the licensee took action to mitigate the imminent risks. Noncompliance remained and the scopes and levels remain unchanged.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
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,	0 480		

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0 480	Continued From page 2 existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated February 17, 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		
0 500 SS=F	144G.41 Subd. 2 Policies and procedures Each assisted living facility must have policies and procedures in place to address the following and keep them current: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (2) conducting and handling background studies on employees; (3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (4) handling complaints regarding staff or services provided by staff; (5) conducting initial evaluations of residents' needs and the providers' ability to provide those services; (6) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (7) orientation to and implementation of the assisted living bill of rights; (8) infection control practices; (9) reminders for medications, treatments, or exercises, if provided; (10) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; (11) ensuring that nurses and licensed health	0 500		

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0 500	Continued From page 4 professionals have current and valid licenses to practice; (12) medication and treatment management; (13) delegation of tasks by registered nurses or licensed health professionals; (14) supervision of registered nurses and licensed health professionals; and (15) supervision of unlicensed personnel performing delegated tasks. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement current policies and procedures 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 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: On February 18, 2025, at 11:50 a.m., assisted living director in residence (ALDIR)-A provided surveyor with a binder titled Eden Homes & Care Services - Policies & Procedures Manual dated July 8, 2025. The licensee failed to provide the following policies and procedures during the survey process: -content of employee records -content of resident records -treatment and therapy services	0 500		

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0 500	Continued From page 5 -infection control -missing resident -emergency preparedness -service plan On February 18, 2026, at 2:18 p.m., assisted living director in residence (ALDIR)-A stated, "I was not aware we were missing policies, but we are still working on them". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 500		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to establish and maintain an infection control program that complied with accepted health care, medical and nursing standards for infection control. The deficient practice had the potential to affect all residents,	0 510		

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0 510	Continued From page 6 employees, 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, 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: On February 18, 2026, at 12:45 p.m., the surveyor verbally requested the assisted living director in residency (ALDIR)-A provide the licensee's infection prevention and control program. On February 18, 2026, at 2:20 p.m., ALDIR-A provided the facilities policy binder and stated tuberculosis (TB) and infection control are summarized in the policy binder. The licensee lacked written evidence of an infection prevention and control program with all the required content as outlined below: - leadership support - education and training on infection prevention - resident, family and visitor education - performance monitoring and feedback - standard precautions - transmission-based precautions On February 23, 2026, at 1:47 p.m., clinical nurse supervisor (CNS)-D stated ALDIR-A informed CNS-D that the infection prevention and control program needed to be created. CNS-D stated, "I didn't do it, I didn't get to it".	0 510		

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0 510	Continued From page 7 The CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings dated April 12, 2024, indicated Core Practices should be implemented in all settings where healthcare is delivered including: - leadership support - education and training on infection prevention - resident, family and visitor education - performance monitoring and feedback - standard precautions - transmission-based precautions A policy was requested but not received. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 510		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the	0 630		

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0 630	Continued From page 8 licensee failed to ensure an individual abuse prevention plan (IAPP) was developed or included a review/assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults and statements of the specific measures to be taken to minimize the risk of abuse for one of one resident (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 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: R2 was admitted to the licensee on February 12, 2026, and began receiving assisted living services. R2's individual abuse prevention plan (IAPP) lacked a review/assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults and statements of the specific measures to be taken to minimize the risk of abuse. On February 23, 2026, at 1:57 p.m. clinical nurse supervisor (CNS)-D stated she was aware she needed to include the missing information. She stated she was not used to using RTask (electronic medical record) and it was missed.	0 630		

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0 630	Continued From page 9 No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
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 observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a facility TB risk assessment, a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test, for three of three employees (assisted living director in residence (ALDIR)-A, unlicensed personnel (ULP)-B, and clinical nurse supervisor (CNS)-D), a completed health history and	0 660		

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0 660	Continued From page 10 symptom screening for one of three employees (CNS-D), and TB training for three of three employees (ALDIR-A,ULP-B, and CNS-D). 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: During the entrance conference on February 17, 2026, at 11:55 a.m., ALDIR-A stated she did not know what a facility risk assessment was and was not aware it needed to be completed. ALDIR-A ALDIR-A was hired on October 31, 2025, to provide direct care services to the licensee's residents and supervision of staff. ALDIR-A's employee file included [the facilities] Mantoux Tuberculin Skin Test form that indicated a negative TST was completed on July 8, 2025. ALDIR-A's file lacked evidence indicating a second step TST was completed. In addition, the file lacked TB training at time of hire. ULP-B ULP-B was hired on November 3, 2025, to provide direct care and services to the licensee's residents On February 19, 2026, at 9:18 a.m., the surveyor observed ULP-B providing medication administration to R2.	0 660		

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0 660	Continued From page 11 ULP-B's employee file included [the facilities] Mantoux Tuberculin Skin Test form that indicated a negative TST was completed on October 6, 2025. ULP-B's file lacked evidence indicating a second step TST was completed. In addition, the file lacked TB training at time of hire. CNS-D CNS-D was hired on November 4, 2025, to provide direct care services to residents and supervision of staff. CNS-D's employee file included documentation that indicated a negative TB Gold test had been completed on December 23,2020, 4 years and 11 months prior to her start date. In addition, the employee file lacked TB training at time of hire and a health history and symptom screening. On February 18, at 2:10 p.m., ALDIR-A stated she was not aware the TB testing that had been completed did not fulfill the requirements. In addition, she stated CNS-D had completed a health history and symptom screening form but was unable to locate it. The Minnesota Department of Health guidelines Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include an annual facility TB risk assessment. The guidelines also indicated an employee may begin working with patients (residents) after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients. Baseline TB	0 660		

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0 660	Continued From page 12 screening should be documented in the employee's record. A tuberculosis policy was requested but not received. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
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. (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.	0 680		

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	42027	A. BUILDING: _____ B. WING _____	02/20/2026

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0 680	Continued From page 13 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 visitors, employees, and residents. 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 the residents). The findings include: The licensee failed to create an EP and lacked the following required information: -establish/maintain a comprehensive EP which describes the facility's approach to meeting health/safety/security needs of staff/residents -address coordination with other health care facilities (HCF), as well as community on a whole during emergency or disaster (natural, man-made, facility, etc.) -must be reviewed/updated annually -complete a risk assessment that considers hazards like care related emergencies, equipment/utility failures, interruptions in communications/cyber-attacks, loss of all or portion of a facility, interruption to normal supply of essential resources and medical supplies -develop strategies for addressing facility and community-based risks (i.e.: evacuation plans, staffing surges/shortages, back-up plans)	0 680		

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0 680	Continued From page 14 -quarterly review of the missing resident plan -identify at risk population needs like maintaining independence, communication, transportation, supervision and medical care -identify which staff would assume specific roles in another's absence through succession planning and delegation of authority -include a process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response -develop and implement EP policies/procedures (P/P) based on the EP, risk assessment & communication plan -subsistence needs for staff and patients including food, water, medical supplies, pharmaceutical supplies, and alternate sources of energy to maintain. -system to track the location of on-duty staff and sheltered residents -if on-duty staff and sheltered residents are relocated, facility must document the specific name/location of the receiving facility or other location -safe evacuation from the facility, including consideration of care and treatment needs of evacuees, staff responsibilities, transportation, identification of evacuation location(s), and primary/alternate communication means with external sources for assistance -shelter in place for residents, staff, and volunteers who remain in the facility -system of medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records -use of volunteers, including the process/role for integration -development of arrangements with other facilities/providers to receive residents in the event of limitations/cessation of operations to maintain the continuity of services to residents	0 680		

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0 680	Continued From page 15 -role of facility under a waiver declared by the secretary in accordance with section 1135 of the act -communication plan that includes names/contact information: staff, entities providing services under agreement, residents' physicians, other facilities, and volunteers -communication plan must include contact information for the following: federal, state, tribal, regional, local EP staff, state licensing and certification agency, MN office of ombudsman for LTC and other sources of assistance. -primary and alternate means of communicating with: facility staff and federal, state, tribal, regional & local emergency management agencies -method for sharing information and medical documentation for residents under the facility's care, as necessary, with other HCPs to maintain continuity of care -means to providing information about the facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee -method for sharing information from the emergency plan, that the facility has determined appropriate, with residents and their families/representatives -develop and maintain EP training and testing program -implement emergency and standby power systems -if part of a healthcare system consisting of separately certified healthcare facilities elects to have a unified and integrated EPP On February 18, 2026, at 12:30 p.m., assisted living director in residence (ALDIR)-A stated she was not familiar with EPP requirements, and they had not created a plan.	0 680		

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0 680	Continued From page 16 No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
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: 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).	0 790		

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0 790	Continued From page 17 The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated 2-18-26, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) Days.	0 790		
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	0 810		

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0 810	Continued From page 18 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 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 2-18-26, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) Days.	0 810		

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0 910	Continued From page 19	0 910		
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for two of two residents (R2 and R3). 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: R2 was admitted to the licensee and signed an Assisted Living Contract on February 12, 2026, to receive assisted living services. R3 was admitted to the licensee and signed an Assisted Living Contract on February 16, 2026, to	0 910		

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0 910	Continued From page 20 receive assisted living services. R2 and R3's Assisted Living Contract lacked the following required content: -health facility identification of the facility -the authorized agent for the facility On February 19, 2026, at 2:27 p.m., assisted living director in residence (ALDIR)-A stated "I created the contract to the best of my ability. If I missed a lot, I did not know it was needed". No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910		
0 920 SS=C	144G.50 Subd. 2 (c) Contract information (c) The contract must include: (1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; (2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; (3) a delineation of the cost and nature of any other services to be provided for an additional fee; (4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; (5) a delineation of the grounds under which the resident may be transferred or have housing or	0 920		

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0 920	Continued From page 21 services terminated or be subject to an emergency relocation; (6) billing and payment procedures and requirements; and (7) disclosure of the facility's ability to provide specialized diets. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for two of two residents (R2 and R3). 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: R2 was admitted to the licensee and signed an Assisted Living Contract on February 12, 2026, to receive assisted living services. R3 was admitted to the licensee and signed an Assisted Living Contract on February 16, 2026, to receive assisted living services. R2 and R3's Assisted Living Contract lacked a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license.	0 920		

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0 920	Continued From page 22 On February 19, 2026, at 2:27 p.m., assisted living director in residence (ALDIR)-A stated "I created the contract to the best of my ability. If I missed a lot, I did not know it was needed". No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 920		
0 930 SS=C	144G.50 Subd. 2 (d-e; 1-4) Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with	0 930		

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0 930	Continued From page 23 the required content for two of two residents (R2 and R3). 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: R2 was admitted to the licensee and signed an Assisted Living Contract on February 12, 2026, to receive assisted living services. R3 was admitted to the licensee and signed an Assisted Living Contract on February 16, 2026, to receive assisted living services. R2 and R3's Assisted Living Contract lacked the following required content: -the right under section 144G.54 to appeal the termination of an assisted living contract -the facility's policy regarding transfer of residents with the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer -contact information for the Ombudsman for Mental Health and Developmental Disabilities -the residents right to obtain services from an unaffiliated service provider On February 19, 2026, at 2:27 p.m., assisted living director in residence (ALDIR)-A stated "I created the contract to the best of my ability. If I missed a lot, I did not know it was needed".	0 930		

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0 930	Continued From page 24 No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 930		
0 940 SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term	0 940		

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0 940	Continued From page 25 care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for two of two residents (R2 and R3). 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: R2 was admitted to the licensee and signed an Assisted Living Contract on February 12, 2026, to receive assisted living services. R3 was admitted to the licensee and signed an Assisted Living Contract on February 16, 2026, to receive assisted living services. R2 and R3's Assisted Living Contract lacked a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: -whether the facility is enrolled with the commissioner of human services to provide customized living services under medical	0 940		

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0 940	Continued From page 26 assistance waivers -whether the facility has an agreement to provide housing support under section 256l.04, subdivision 2, paragraph (b) -whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided -whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required -a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent -a statement that residents may be eligible for assistance with rent through the housing support program -a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program -the contact information to obtain long-term care consulting services under section 256B.0911 -the toll-free phone number for the Minnesota Adult Abuse Reporting Center On February 19, 2026, at 2:27 p.m., assisted living director in residence (ALDIR)-A stated "I created the contract to the best of my ability. If I	0 940		

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0 940	Continued From page 27 missed a lot, I did not know it was needed". No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 940		
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative.	0 950		

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0 950	Continued From page 28 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract included the designation of representative statutory language for two of two residents (R2 and R3). 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: R2 was admitted to the licensee and signed an Assisted Living Contract on February 12, 2026, to receive assisted living services. R3 was admitted to the licensee and signed an Assisted Living Contract on February 16, 2026, to receive assisted living services. R2 and R3's Assisted Living Contract lacked the verbatim notice and a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declined to name a designated representative. On February 19, 2026, at 2:27 p.m., assisted living director in residence (ALDIR)-A stated "I created the contract to the best of my ability. If I missed a lot, I did not know it was needed". No further information was provided.	0 950		

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0 950	Continued From page 29 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was submitted and completed for the current health facility identification (HFID) number for two of four employees (unlicensed personnel (ULP)-B, and ULP-C on the facility provided employee roster. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems	01290		

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01290	Continued From page 30 are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). This resulted in an immediate correction order issued on February 18, 2026. The findings include: On February 17, at 1:05 p.m., the surveyor reviewed the facility's NETStudy 2.0 (background study) roster and compared it to the facility's staff roster and discovered two of the facility's employees were not listed as having a background study submitted with the licensee's HFID 42027. ULP-B was hired on November 3, 2025, to provide direct care and services to the licensee's residents. ULP-B provided direct care services without direct supervision on February 12, 13, 14, 15, and 16, 2026. A background study had not been completed for ULP-B. ULP-C was hired on December 9, 2025, to provide direct care and services to the licensee's residents. ULP-C provided direct care services without direct supervision on January 1, 5, 7, 9, and 10, 2026. A background study had not been completed for ULP-C. On February 17, 2026, at 2:33 p.m., assisted living director in residence (ALDIR)-A stated she started the BGS process for ULP-B but failed to complete it. In addition, ALDIR-A stated she had not initiated a BGS for ULP-C. The licensee's undated Background Studies Policy indicated [the facility] will conduct background studies on all individuals as required	01290		

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01290	Continued From page 31 by Minnesota Statutes Section 245C prior to employment or affiliation. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	01290		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed supervision of	01440		

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01440	Continued From page 32 unlicensed personnel within 30 calendar days of beginning to provide delegated tasks for one of one 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 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-B was hired on November 3, 2025, to provide direct care services to residents. On February 19, 2026, at 9:18 a.m., the surveyor observed ULP-B providing medication administration to R2. ULP-B's record lacked evidence that an RN conducted direct supervision of ULP-B within 30 days of performing delegated tasks. On February 23, 2026, at 1:45 p.m., clinical nurse supervisor (CNS)-D stated she thought a 30-day supervision had been done but was not sure. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following	01470		

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01470	Continued From page 33 topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation 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	01470		

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01470	Continued From page 34 topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (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 orientation to assisted living facility licensing requirements and regulations included all required content for two of two employees (assisted living director in residence (ALDIR)-A and 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) 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: ALDIR-A began employment on October 31,	01470		

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01470	Continued From page 35 2025, to provide direct care services to residents and supervision of staff. ULP-B began employment on November 3, 2025, to provide direct care services to residents. On February 19, 2026, at 9:18 a.m., the surveyor observed ULP-B providing medication administration to R2. ALDIR-A and ULP-B employee records lacked the following required orientation content: -overview of assisted living statutes -review of provider's policies and procedures -handling emergencies and using emergency services -handing of resident complaints, reporting of complaints, where to report -consumer advocacy services -review of types of assisted living services the employee will provide and provider's scope of license -principles of person-centered planning/service delivery On February 19, 2026, at 2:56 p.m., ALDIR-A stated the staff are trained using EduCare (on-line training program) and RTasks LMS (electronical medical record learning management system). Surveyor verbally requested ALDIR-A provide training documents for ALDIR-A and ULP-B on February 17, 2026, at 3:01 p.m., and February 18th, 2026, at 2:26 p.m. In addition, surveyor requested ALDIR-A provide training documents via e-mail request on February 19, 2026, at 12:55 a.m. Documents received were incomplete and lacked the required orientation content.	01470		

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01470	Continued From page 36 The licensee's Staff Training and Competency Policy dated November 9, 2025, indicated all staff will complete comprehensive orientation, ongoing training, and competency evaluations to maintain high standards of care. No further information provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01490 SS=F	144G.63 Subd. 4 Training required relating to dementia, menta All direct care staff and supervisors providing direct services must demonstrate an understanding of the training specified in section 144G.64. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure staff received dementia care training in the required areas for two of two employees (assisted living director in residence (ALDIR)-A and 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) 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).	01490		

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01490	Continued From page 37 The findings include: ALDIR-A began employment on October 31, 2025, to provide direct care services to residents and supervision of staff. ULP-B began employment on November 3, 2025, to provide direct care services to residents. On February 19, 2026, at 9:18 a.m., the surveyor observed ULP-B providing medication administration to R2. ULP-B and ALDIR-A employee records lacked evidence of completing dementia care training in the following topics: -an explanation of Alzheimer's disease and other dementia's -assistance with activities of daily living -problem solving with challenging behaviors -communication skills -person-centered planning and service delivery -recognizing symptoms of common mental illness diagnoses, including but not limited to mood disorders, anxiety disorders, trauma- and stressor-related disorders, personality and psychotic disorders, substance use disorder, and substance misuse -de-escalation techniques and communication -crisis resolution and suicide prevention, including procedures for contacting county crisis response teams and 988 suicide and crisis lifelines On February 19, 2026, at 2:56 p.m., ALDIR-A stated the staff are trained using EduCare (on-line training program) and RTasks LMS (electronical medical record learning management system). ALDIR-A provided a form titled [the facility] Employee Orientation from	01490		

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01490	Continued From page 38 ULP-B's employee file indicating training had been completed, however, no proof of training module completion from their learning programs was provided. Surveyor requested training documents for ALDIR-A and ULP-B on February 17, 18, 19, and 23, 2026. No documents regarding dementia training were received. The licensee's Staff Training and Competency Policy dated November 9, 2025, indicated all staff will complete comprehensive orientation, ongoing training, and competency evaluations to maintain high standards of care. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01490		
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;	01530		

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01530	Continued From page 39 (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct care staff received the required 2 hours of initial training on mental illness and de-escalation topics effective July 1, 2025, and failed to ensure employees received eight hours of initial dementia care training within the first 160 hours worked for two of two employees (assisted living director in residence (ALDIR)-A and unlicensed personnel (ULP)-B). This had the potential to affect all residents and staff.	01530		

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01530	Continued From page 40 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 the residents). The findings include: ALDIR-A began employment on October 31, 2025, to provide direct care services to residents and supervision of staff. ULP-B began employment on November 3, 2025, to provide direct care services to residents. On February 19, 2026, at 9:18 a.m., the surveyor observed ULP-B providing medication administration to R2. On February 19, 2026, at 2:56 p.m., ALDIR-A stated the staff are trained using EduCare (on-line training program) and RTasks LMS (electronical medical record learning management system). Surveyor verbally requested ALDIR-A provide training documents for ALDIR-A and ULP-B on February 17, 2026, at 3:01 p.m., and February 18th, 2026, at 2:26 p.m. In addition, surveyor requested ALDIR-A provide training documents via e-mail request on February 19, 2026, at 12:55 a.m. Documents received were incomplete and lacked the required orientation content. The licensee's Staff Training and Competency Policy dated November 9, 2025, indicated all staff	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	42027	A. BUILDING: _____ B. WING _____	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDEN HOMES & CARE SERVICES LLC	18741 IVANHOE ST NW ELK RIVER, MN 55330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01530	Continued From page 41 will complete comprehensive orientation, ongoing training, and competency evaluations to maintain high standards of care. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	42027	A. BUILDING: _____ B. WING _____	02/20/2026

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EDEN HOMES & CARE SERVICES LLC	18741 IVANHOE ST NW ELK RIVER, MN 55330

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01940	Continued From page 42 treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to develop and implement a current treatment or therapy management plan to include all required content for one of two residents (R2) who received treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted to the licensee on February 12, 2026, and began receiving assisted living services. R2's diagnoses included cerebral infarction, aphasia, suicide attempt, type II diabetes mellitus without complications. R2's unsigned Service Plan dated February 12, 2026, indicated R2 received assistance with glucose (blood sugar) monitoring and a prosthetic device (leg brace). R2's Service Recap Summary - Month dated February 2026, indicated R2 received prosthetic device assistance in the morning and at bedtime	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	42027	A. BUILDING: _____ B. WING _____	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDEN HOMES & CARE SERVICES LLC	18741 IVANHOE ST NW ELK RIVER, MN 55330

(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
01940	Continued From page 43 on February 16, 17 ,18, and 19, 2026. In addition, it indicated R2 had glucose, (blood sugar) monitoring twice daily at five a.m. and eight a.m. on February 14, 15, 16, 17, 18, and 19, 2026. R2's record lacked an individualized treatment plan for the prosthetic device and glucose monitoring. On February 19, 2026, at 2:51 p.m., assisted living director in residence (ALDIR)-A stated she was aware a treatment plan was needed, but one had not been done yet. She further stated Allina Health physical therapy staff had asked how they were putting the brace on and educated the staff on what to do. On February 23, 2026, at 1:50 p.m., clinical nurse supervisor (CNS)-D stated she was unsure about R2's blood sugars and she was not aware that R2 had a prosthetic device. CNS-D stated she did not complete a treatment plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	42027	A. BUILDING: _____ B. WING _____	02/20/2026

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EDEN HOMES & CARE SERVICES LLC	18741 IVANHOE ST NW ELK RIVER, MN 55330

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01950	Continued From page 44 or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record for one of one resident (R2) who received glucose (blood sugar) monitoring and had a prosthetic device (leg brace). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted to the licensee on February 12, 2026, and began receiving assisted living services. R2's diagnoses included cerebral infarction,	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	42027	A. BUILDING: _____ B. WING _____	02/20/2026

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01950	Continued From page 45 aphasia, suicide attempt, type II diabetes mellitus without complications. R2's unsigned Service Plan dated February 12, 2026, indicated R2 received assistance with glucose monitoring and a prosthetic device. On February 19, 2026, at 9:18 a.m., the surveyor observed unlicensed personnel (ULP)-B complete a scheduled glucose monitoring check after R2 had eaten breakfast. On February 19, 2026, at 12:32 p.m., the surveyor observed ULP-B provide prosthetic device assistance. R2's admission orders dated February 11, 2026, indicated blood-glucose meter - twice daily before breakfast and dinner. R2 lacked an order for the prosthetic device. R2's Service Recap Summary - Month dated February 2026, indicated R2 received prosthetic device assistance in the morning and at bedtime on February 16, 17 ,18, and 19, 2026. In addition, it indicated R2 had glucose monitoring twice daily at five a.m. and eight a.m. on February 14, 15, 16, 17, 18, and 19, 2026. R2's medical record lacked specific instructions regarding glucose monitoring and the prosthetic device. On February 19, 2026, at 9:23 a.m., ULP-B stated he knew the blood sugar should be checked before the resident eats but forgot this morning. On February 19, 2026, at 12:32 p.m., ULP-B stated, "homecare comes and visits her and tells	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	42027	A. BUILDING: _____ B. WING _____	02/20/2026

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01950	Continued From page 46 us how to work with the brace and staff know what to do". On February 19, 2026, at 2:51 p.m., assisted living director in residence (ALDIR)-A stated there was not a physician order in R2's medical record regarding the prosthetic device. She further stated Allina Health physical therapy staff had asked how the staff were putting the brace on and educated the staff on what to do On February 23, 2026, at 1:50 p.m., clinical nurse supervisor (CNS)-D stated she was unsure about R2's blood sugars and she was not aware that R2 had a prosthetic device. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
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 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 written or electronically recorded orders were maintained for one of one resident (R2) receiving	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01970	Continued From page 47 treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted on February 12, 2026, and began receiving assisted living services. On February 19, 2026, at 12:32 p.m., the surveyor observed ULP-B provide prosthetic device (leg brace) assistance. R2's unsigned Service Plan dated February 12, 2026, indicated R2 received assistance with a prosthetic device. R2's medical record lacked an order regarding a prosthetic device. On February 19, 2026, at 2:51 p.m., assisted living director in residence (ALDIR)-A stated there was not a physician order in R2's medical record regarding the prosthetic device. On February 23, 2026, at 1:50 p.m., clinical nurse supervisor (CNS)-D stated she was not aware that R2 had a prosthetic device. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01970	Continued From page 48 days	01970		

St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Eden Homes & Care Services LLC
18741 Ivanhoe St NW
Elk River, MN 55330
Sherburne County
Parcel:

Phone:

License Info

License: HFID 42027

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

Inspection Info

Report Number: F1051261033
Inspection Type: Full - Single
Date: 2/17/2026 Time: 12:00:00 PM
Duration: 45 minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 3
Total Priority 3 Orders: 2
Delivery: Emailed

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:
SEND IN A FULL TIME EMPLOYEE TO TAKE AN APPROVED 8 HOUR FOOD SAFETY TRAINING CLASS. ONCE THEY HAVE PASSED THE CLASS & RECEIVED A CERTIFICATE, HAVE THEM SUBMIT THAT TO MDH'S ONLINE APPLICATION. CERTIFIED FOOD PROTECTION MANAGER FACT SHEET WILL BE PROVIDED WITH REPORT VIA EMAIL.
Comply By: 4/17/2026 Originally Issued On: 2/17/2026

New Order: 3-300B Protection from Contamination: cross-contamination, eggs
3-302.12 *Priority Level: Priority 3 CFP#: 37*
MN Rule 4626.0240 Properly label all working containers holding food or food ingredients that are removed from original packages with the common name of the food. Label the food in English and any other languages used by employees who handle food.
COMMENT:
AT THE TIME OF INSPECTION, THE CONTAINER OF RICE AND SPICES IN THE PANTRY ARE NOT LABELED.
Comply By: 2/17/2026 Originally Issued On: 2/17/2026

New Order: 4-300 Equipment Numbers and Capacities
4-302.12A *Priority Level: Priority 2 CFP#: 36*
MN Rule 4626.0705A Provide a readily accessible food temperature measuring device to ensure attainment and maintenance of food temperatures.
COMMENT:
AT THE TIME OF INSPECTION, THERE IS NO THERMOMETER INSIDE THE KITCHEN UPRIGHT COOLER.
Comply By: 2/20/2026 Originally Issued On: 2/17/2026

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:
AT THE TIME OF INSPECTION, THERE IS NO THERMOMETER ON-SITE TO MEASURE THE FOOD'S TEMPERATURE.
Comply By: 2/20/2026 Originally Issued On: 2/17/2026

New Order: 4-300 Equipment Numbers and Capacities
4-302.13B *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.
COMMENT:
PROVIDE A WATERPROOF THERMOMETER OR THERMOLABEL STICKERS FOR THE HIGH TEMPERATURE DISH MACHINE.
Comply By: 2/20/2026 Originally Issued On: 2/17/2026

Food & Beverage General Comment

CONTACTED THE NURSE SURVEYOR, LISA SCHWINTEK, AFTER COMPLETING THE INSPECTION.

DISCUSSED THE FOLLOWING WITH THE FOOD SERVICE DIRECTOR, DELVIN:

EMPLOYEE ILLNESS LOG
VOMIT CLEAN-UP PROCEDURES
HANDWASHING & GLOVE USE/DISPOSAL
DATEMARKING & DISPOSITION OF TCS FOOD
NOROVIRUS
CERTIFIED FOOD PROTECTION MANAGER
THERMOMETERS

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 St Cloud District Office inspection report number F1051261033 from 2/17/2026

Delvin
Food Service Director

Kai Yang,
Public Health Sanitarian 1
320-640-3532
kai.yang@state.mn.us

St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301

Temperature Observations/Recordings

Establishment Info

Eden Homes & Care Services LLC
Elk River
County/Group: Sherburne County

Inspection Info

Report Number: F1051261033
Inspection Type: Full
Date: 2/17/2026
Time: 12:00:00 PM

Food Temperature: Product/Item/Unit: MILK**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 39 Degrees F.
Comment:
Violation Issued?: No

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL42027015-0	**Date:** 2/18/2026
Facility Name: EDEN HOMES & CARE SERVICES LLC	
Facility Address: 18741 IVANHOE ST NW ELK RIVER, MN	

☒ **TAG IDENTIFICATION: 0790**

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

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

   Comments: Fire Extinguisher in the kitchen was mounted incorrectly at a height over 60 inches. Minnesota State Fire Code 906.9.1 fire extinguishers shall be installed so that their tops are not more than 5 feet (60 inches) above the floor.

☒ **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 that include employee actions to be taken in the event of a fire or similar emergency. [Minn. Stat. 144G.45 subd.2]

   Comments: The licensee failed to ensure the fire safety and evacuation plan (FSEP) included site-specific staff actions to be implemented in the event of a fire or similar emergency, as related to the facility's building layout.

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

   Comments: The licensee failed to ensure the FSEP included site-specific Resident actions to be implemented in the event of a fire or similar emergency.

3. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include 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. [Minn. Stat. 144G.45 subd.2]

   Comments: The FSEP failed to include relocation locations in the event the facility is no longer occupiable due to fire or other emergency situation.

4. Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. [Minn. Stat. 144G.45 subd.2]

   Comments: No training documentation was provided for staff upon hire. ALDIR-A stated that she speaks with staff upon hire about the FSEP.