Electronically Delivered

April 29, 2026

Licensee
Boden Senior Living Apple Valley
5399 155th Street West
Apple Valley, MN 55124

RE: Project Number(s) SL38743016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 1, 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.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. 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 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00

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

DOCUMENTATION OF ACTION TO COMPLY
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. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38743	A. BUILDING: _____ B. WING _____	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BODEN SENIOR LIVING APPLE VALLEY	5399 155TH STREET WEST APPLE VALLEY, MN 55124

(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: SL38743016-0 On March 30, 2026, through April 1, 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 59 residents; 57 receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480		

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 March 31, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer	0 480		

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0 480	Continued From page 3 to the FBEIR for any compliance dates.	0 480		
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 maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included a two-step TST (tuberculin skin test) or other evidence of tuberculosis (TB) screening such as a blood test for two of two employees (unlicensed personnel (ULP)-D and ULP-E). This practice resulted in a level two violation (a violation that did no 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	0 660		

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0 660	Continued From page 4 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-D ULP-D was hired on June 20, 2022, to provide direct care and services to the licensee's residents. ULP-D's employee record included a TB Screening dated August 19, 2025; however, it lacked evidence of a two-step TST or other evidence of TB screening such as a blood test. ULP-E ULP-E was hired on January 26, 2024, to provide direct care and services to the licensee's residents. ULP-E's employee record included a TB Screening dated August 19, 2025; however, it lacked evidence of a two-step TST or other evidence of TB screening such as a blood test. On March 31, 2026, at 12:54 p.m., regional director of clinical services (RDCS)-F stated ULP-D and ULP-E's record lacked evidence of a two-step TST or other evidence of TB screening such as a blood test. RDCS-F stated the clinic the licensee used for staff testing recently closed and they were unable to request copies of ULP-D and ULP-E's test results. The licensee's TB Infection Control Plan policy dated June 2023, indicated all healthcare workers should receive baseline TB screening upon hire using at two-step TST or single blood test to test for infection.	0 660		

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0 660	Continued From page 5 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, 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 March 31, 2026, for the specific violations related the physical environment under Minnesota Statute 144G.	0 775		

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0 775	Continued From page 6 TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	0 810		

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0 810	Continued From page 7 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 March 31, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	0 810		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective	01620		

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01620	Continued From page 8 resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a	01620		

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01620	Continued From page 9 prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted timely ongoing nursing assessments for three of three residents (R1, R2 and R3). In addition, the licensee failed to complete fall assessments/follow up for two of two residents (R1 and R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1 was admitted on July 17, 2025, with diagnoses that included dementia. R1's service agreement dated March 27, 2026, indicated R1 received services to include grooming, dressing, toileting/incontinence, bathing, transfers, escorts, safety checks, diet/nutrition management and medication administration. R1's record included nursing assessments dated August 1, 2025, (completed on August 4, 2025),	01620		

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01620	Continued From page 10 January 21, 2026 (completed on January 22, 2026) and March 17, 2026 (completed on March 23, 2026). The January 21, 2026, (completed on January 22, 2026) assessment was completed 171 days after the date of the previous assessment, thus exceeding 90 days. R2 R2 was admitted on August 23, 2025, with diagnoses that included Parkinson's disease (progressive movement disorder of the nervous system leading to problems with movement, tremor, stiffness, and impaired balance). R2's service agreement dated March 18, 2026, indicated R2 received services to include bathing, toileting, meal assistance, safety checks, and medication administration. R2's record included nursing assessments dated September 8, 2025, (completed on September 12, 2025), September 17, 2025, (completed on September 18, 2025), and March 3, 2026, (completed on March 4, 2026). The March 3, 2026, (completed on March 4, 2026) assessment was completed 167 days after the date of the previous assessment, thus exceeding 90 days. R3 R3 was admitted on March 19, 2024, with diagnoses that included diabetes. R3's service agreement dated February 20, 2026, indicated R3 received services to include dressing, toileting/incontinence assist, transfers, escorts, safety checks, blood glucose checks,	01620		

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01620	Continued From page 11 oxygen management and medication and insulin administration. R3's record included nursing assessments dated April 24, 2025 (completed on May 21, 2025), August 4, 2025, and February 19, 2026 (completed on March 3, 2026). The February 19, 2026, (completed on March 3, 2026) assessment was completed 183 days after the date of the previous assessment, thus exceeding 90 days. On April 1, 2026, at 9:49 a.m., regional director of clinical services (RDCS)-F stated the licensee had identified the completion of nursing assessments as an area that needed improvement and had already started making changes to ensure assessments were completed within the required timeframe going forward. The licensee's Comprehensive Assessment Schedule policy dated August 2022, indicated ongoing resident monitoring and reassessment would be completed at least every 90 days. FALLS R1 R1's fall reports and record review indicated the following falls and findings: -Resident incident report dated November 3, 2025, indicated R1 had an unwitnessed fall and was found sitting next to her recliner. -Resident contributing factors: attempted self-transfer, confused -Resident follow up and prevention: education family/resident on environment safety, ensure proper use of assistive device, ensure staff are following service plan.	01620		

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	38743	A. BUILDING: _____ B. WING _____	04/01/2026

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01620	Continued From page 12 -Resident incident report dated December 3, 2025, indicated R1 had a witnessed fall while attempting to stand up. -Resident contributing factors: weakness, age, unsteady/gait -Resident follow up and prevention: ensure proper footwear is available, ensure proper use of assistive device, ensure staff are following service plan. -Resident incident report dated December 23, 2025, indicated R1 had an unwitnessed fall in her room and was found lying on the floor in front of her recliner. -Resident contributing factors: agitation, altered mental status, attempted self-transfer, confused, fall history, gait/balance disorder, impaired cognition diagnosis, impaired decision making, impaired mental status, impaired safety judgment, impulsive, weakness -Resident follow up and prevention: instructed on safety measures, education family/resident on environment safety, ensure proper use of assistive device, ensure staff are following service plan. -Resident incident report dated December 30, 2025, indicated R1 had an unwitnessed fall in her room and was found lying on the floor in front of her recliner. -Resident contributing factors: agitation, altered mental status, attempted self-transfer, behaviors, confused, fall history, gait/balance disorder, impaired cognition diagnosis, impaired decision making, impaired mental status, impaired safety judgement, impulsive, weakness -Resident follow up and prevention: educate resident to use assistive device, education on safety, provided education on fall reduction,	01620		

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01620	Continued From page 13 reminders given to request or wait for staff assistance per scheduled service plan. -Resident incident report dated February 10, 2026, indicated R1 had an unwitnessed fall in her room and was found sitting on the floor next to her bed. -Resident contributing factors: agitation, attempted self-transfer, fall history, gait/balance disorder, impaired decision making, impaired safety judgment -Resident follow up and prevention: education on safety, re-educated on pendant use, reminders, redirection, cues. -Resident incident report dated February 14, 2026, indicated R1 had an unwitnessed fall in her room and was found lying on her back in the bathroom. -Resident contributing factors: agitation, attempted self-transfer, behaviors, confused, fall history, gait/balance disorder, history of falls, impaired cognition diagnoses, impaired decision making, impaired mental status, impaired safety judgment, impulsive, inappropriate footwear on prior to fall, resident did not request or wait for assist, weakness. -Resident follow up and prevention: provided education on fall reduction strategy, provided education on fall risk, reminder give to request or wait for staff assistance per scheduled service plan. -Resident incident report dated February 14, 2026, indicated R1 had second unwitnessed fall in her bathroom. -Resident contributing factors: attempted to self-transfer, fall history, gait/balance disorder, impaired decision making, impaired safety judgement.	01620		

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01620	Continued From page 14 -Resident follow up and prevention: education on safety, re-education on pendant use, reminders, redirection, cues. -Resident incident report dated February 28, 2026, indicated R1 had a witnessed fall during a transfer. -Resident contributing factors: age, muscle weakness, unsteady/gait -Resident follow up and prevention: education to change positions slowly, education on safety. The licensee's RN failed to identify root cause analysis of R1's falls and implement interventions to minimize future falls. R2 R2's fall reports and record review indicated the following falls and findings: -Resident incident report dated October 3, 2025, indicated R2 had an unwitnessed fall in his room and was found on the floor next to his bed. -Resident contributing factors: attempted self-transfer, history of falls, resistive to cares, weakness, Parkinson's disease -Resident follow up and prevention: bed and furniture height assessed for appropriateness -Resident incident report dated October 10, 2025, indicated R2 had an unwitnessed fall and was found on the floor in front of his chair. -Resident contributing factors: fall history, impaired judgment, impulsive weakness, black cushion on his recliner -Resident follow up and prevention: removed black cushion from recliner, asked family to provide no slip pad to prevent sliding, reminder given to request or wait for staff assistance per scheduled service plan	01620		

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01620	Continued From page 15 -Resident incident report dated October 18, 2025, indicated R2 had an unwitnessed fall and was found on the floor in a sitting position. -Resident contributing factors: Parkinson's disease, agitation, altered mental status, attempted self-transfer, behaviors, confused, fall history, gait/balance disorder -Resident follow up and prevention: increase safety checks, increased monitoring, keep door open -Resident incident report dated October 31, 2025, indicated R2 had an unwitnessed fall and was found sitting on the floor in his room. -Resident contributing factors: altered mental status, attempted self-transfer, behaviors, confused, fall history, gait/balance disorder, impaired cognition diagnosis, impaired decision making -Resident follow up and prevention: increased safety checks, increased monitoring, keeping apartment door open -Resident incident report dated November 25, 2025, indicated R2 had slid out of his recliner -Resident contributing factors: muscle weakness, Parkinson's disease, altered mental status, gait/balance disorder, history of falls, impulsive. -Resident follow up and prevention: education on safety, provided education, provided education on fall risk. -Resident incident report dated November 27, 2025, indicated R2 fell during a transfer with his wife. -Resident contributing factors: Age, Parkinson's disease, unsteady/gait -Resident follow up and prevention: Education	01620		

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01620	Continued From page 16 provided to wife , instructed on safety measures, reminder given to request or wait for staff assistance per scheduled service plan. -Resident incident report dated December 18, 2025, indicated R2 had an unwitnessed fall and was found lying on the floor next to his bed. -Resident contributing factors: agitation, altered mental status, attempted self-transfer, behaviors, confused, fall history, history of falls, impaired cognition diagnosis, impaired decision making, impaired mental status, impaired safety judgment, impulsive, resident did not request or wait for assist, weakness -Resident follow up and prevention: reminder given to request or wait for staff assistance per scheduled service plan, re-education on safety. -Resident incident report dated January 17, 2026, indicated R2 had an unwitnessed fall in his room and was found sitting next to his bed. -Resident contributing factors: attempted self-transfer, history of falls, resistive to cares, weakness, Parkinson's disease -Resident incident report dated February 21, 2026, indicated R2 had an unwitnessed fall in his room and was found on the floor near his chair. -Resident contributing factors: altered mental status, attempted self-transfer, fall history, gait/balance disorder, impaired cognition diagnosis, impaired safety judgment -Resident follow up and prevention: increased monitoring, keeping apartment door open -Resident incident report dated February 27, 2026, indicated R2 had an unwitnessed fall in his room and was found on his knees by his bed. -Resident contributing factors: agitation, altered mental status, attempted self-transfer,	01620		

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01620	Continued From page 17 behaviors, confused, fall history, gait/balance disorder, impaired cognition diagnosis, impaired decision making, impaired mental status, impaired safety judgment, impulsive, weakness. -Resident incident report dated March 20, 2026, indicated R2 had an unwitnessed fall in his room and was found kneeling next to his bed. -Resident contributing factors: agitation, altered mental status, attempted self-transfer, behaviors, confused, fall history, gait/balance disorder, impaired cognition diagnosis, impaired decision making, impaired mental status, impaired safety judgment, impulsive, weakness. -Resident follow up and prevention: education on safety, instructed on safety measures, provided education on fall risks, reminder given to request or wait for staff assistance per scheduled service plan. The licensee's RN failed to identify root cause analysis of R2's falls and implement interventions to minimize future falls. On April 1, 2026, at 10:11 a.m., clinical nurse supervisor (CNS)-B stated after each fall, the nurse would assess the resident and implement interventions to prevent future falls. However, CNS-B stated R1 and R2's record lacked documentation of specific root cause analysis, and the specific interventions implemented after each fall to prevent future falls. The licensee's Fall Risk Mitigation and Response policy dated December 2025, indicated the nurse implements fall mitigation interventions appropriate to the perceived reason/root cause of the fall and documents in resident's service plan. No further information was provided.	01620		

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01620	Continued From page 18 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a written service plan was revised to reflect the current services provided for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01640		

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01640	Continued From page 19 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 August 23, 2025, with diagnoses that included Parkinson's disease (progressive movement disorder of the nervous system leading to problems with movement, tremor, stiffness, and impaired balance). On March 31, 2026, at 7:18 a.m., the surveyor observed unlicensed personnel (ULP)-E administer medications to R2. ULP-E stated R2 required assistance with all activities of daily living which included grooming, dressing, toileting, bathing, transfers, and escorts. R2's service agreement dated March 18, 2026, indicated R2 received services to include bathing, toileting, meal assistance, safety checks, and medication administration. R2's service checkoff list dated March 2026, indicated the staff assisted R2 with the following services: -safety checks toileting/incontinence assistance -meal assistance -medication administration -transfer assist 2 -bathing: physical assist 2 -dressing: physical assist 1 R2's record lacked documentation of grooming	01640		

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01640	Continued From page 20 and escort assistance. R2's service agreement did not include grooming, transfers and escorts. On April 1, 2026, at 9:54 a.m., clinical nurse supervisor (CNS)-B reviewed R2's service agreement and stated it did not include grooming, transfers and escorts. CNS-B stated the services were listed under notes and not in the service section which was why grooming, transfers and escorts were not listed on R2's service plan. CNS-B stated he would update R2's service plan to include all services received. The licensee's Service Plan policy dated September 2023, indicated all services provided to residents will be delivered after an assessment by an RN is completed, an up-to date service plan is signed by an RN and the resident or the resident's designated representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's	01730		

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01730	Continued From page 21 assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized medication management plan with the required content for one of three residents	01730		

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01730	Continued From page 22 (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on March 30, 2026, at approximately 9:25 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to their residents at the facility. CNS-B stated medications were stored in a locked cabinet in the residents' bathroom. CNS-B stated narcotic medications are stored in a locked box within the locked medication cabinet in the resident bathroom and medications requiring temperature control were stored in the medication refrigerator. R3 was admitted on March 19, 2024, with diagnoses that included diabetes. On March 31, 2026, at 6:48 a.m., the surveyor observed unlicensed personnel (ULP)-D administer medications and insulin to R3. R3's service agreement dated February 20, 2026, indicated R3 received services to include medication and insulin administration. R3's individualized medication management plan dated February 19, 2026, (completed on March 3, 2026), indicated medications were stored in a	01730		

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01730	Continued From page 23 locked medication cabinet in resident's bathroom and controlled substances were stored in a separate lock box inside the mediation cabinet. On April 1, 2026, at 9:58 a.m., CNS-B reviewed R3's medication management plan and stated it did not include storage in the refrigerator for R3's insulin. The licensee's Medication and Treatments policy dated March 2021, indicated the medication and treatment management plan will be completed for all tenant's receiving services prior to initiating services, annually and with change in condition. 1. The medication and treatment management plan will describe the medication or treatment service provided 2. A description of storage of medications 3. Documentation of tenant specific instructions for medications or treatments 4. Identify the person responsible for ordering supplies and assuring medications are refilled timely 5. The plan will identify which medications or treatments are delegated to unlicensed personnel 6. The plan will identify the procedure for notifying the registered nurse or other licensed staff when a problem arises 7. The plan will identify tenant specific instructions for documenting medication or treatment administration verification 8. The medication and treatment record must be kept current and updated with any changes 9. The medication and treatment management plan will identify measures for preventing a diversion of medications by tenants or others who have access to the medication No further information was provided.	01730		

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01730	Continued From page 24 TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01770 SS=D	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure documentation of medication set up included all the required content for one of one resident (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on March 30, 2026, at approximately 9:25 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to their residents, including medication setup. R5 was admitted on August 24, 2023, with diagnoses that included high blood pressure.	01770		

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BODEN SENIOR LIVING APPLE VALLEY	5399 155TH STREET WEST APPLE VALLEY, MN 55124

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01770	Continued From page 25 R5's service agreement dated August 20, 2024, indicated R5 received services to include medication setup. R5's medication administration record (MAR) dated March 2026, included the following medications: -carvedilol 6.25 milligrams (mg); take one tablet by mouth twice daily (blood pressure) -daily multivitamin; take one tablet by mouth daily (supplement) -aspirin 81 mg; take one tablet by mouth daily (heart health) -gabapentin 300 mg; take one tablet by mouth twice daily (seizures) -mirabegron 50 mg; take one tablet by mouth at bedtime (overactive bladder) -acetaminophen 500 mg; take two tablets by mouth at bedtime (pain) -atorvastatin 40 mg; take one tablet by mouth daily (cholesterol) -senna plus 8.6-50 mg; take one tablet by mouth at bedtime (constipation) -tamsulosin 0.4 mg; take one capsule by mouth daily (prostate) R5's record lacked documentation by the licensed nurse at the time of setup to include the name of medication, quantity of dose, times to be administered, and route of administration. On April 1, 2026, at 10:02 a.m., CNS-B stated R5 received medications in bottles and they were set up in a medication box for four weeks at a time and the setup was documented at the time of the setup; however, CNS-B stated the documentation of the most recent setup could not be located in R5's record.	01770		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38743	A. BUILDING: _____ B. WING _____	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BODEN SENIOR LIVING APPLE VALLEY	5399 155TH STREET WEST APPLE VALLEY, MN 55124

(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
01770	Continued From page 26 The licensee's Medications and Treatments policy dated March 2021, indicated the licensed nurse sets up medication weekly into the dosage boxes utilizing a printed MAR to verify medications placed in the box according to physician orders. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) Days	01770		
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	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38743	A. BUILDING: _____ B. WING _____	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BODEN SENIOR LIVING APPLE VALLEY	5399 155TH STREET WEST APPLE VALLEY, MN 55124

(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 27 possible complications or adverse reactions. The 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 observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for two of three residents (R1 and R2) with 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: On March 31, 2026, at 8:38 a.m., the surveyor observed R1 and R2 eating breakfast. R1's meal consisted of a mechanical soft diet with nectar thickened fluids. R2's meal consisted of a mechanical soft diet. R1 R1 was admitted on July 17, 2025, with diagnoses that included dementia. R1's service agreement dated March 27, 2026, indicated R1 received services to include diet/nutrition management R1's signed prescriber orders dated March 19,	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38743	A. BUILDING: _____ B. WING _____	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BODEN SENIOR LIVING APPLE VALLEY	5399 155TH STREET WEST APPLE VALLEY, MN 55124

(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 28 2026, included the following: -mechanical soft diet with nectar thickened liquids R1's treatment evaluation plan dated March 17, 2026, (completed on March 23, 2026), indicated R1 had "no tx (treatments) at this time". R1's record lacked a treatment management plan to include the following required content: - statement of the type of service that will be provided; - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that will be delegated to unlicensed personnel; - procedures for notifying a registered nurse when a problem arose with treatments or therapy services; and - 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. R2 R2 was admitted on August 23, 2025, with diagnoses that included Parkinson's disease (progressive movement disorder of the nervous system leading to problems with movement, tremor, stiffness, and impaired balance). R2's service agreement dated March 18, 2026, indicated R2 received services to include meal assistance. R2's signed prescriber orders dated March 3, 2026, included the following: -mechanical soft diet	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38743	A. BUILDING: _____ B. WING _____	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BODEN SENIOR LIVING APPLE VALLEY	5399 155TH STREET WEST APPLE VALLEY, MN 55124

(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 29 R2's treatment evaluation plan dated March 3, 2026, (completed on March 4, 2026), indicated R2 had "no current treatments". R2's record lacked a treatment management plan to include the following required content: - statement of the type of service that will be provided; - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that will be delegated to unlicensed personnel; - procedures for notifying a registered nurse when a problem arose with treatments or therapy services; and - 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. On April 1, 2026, at 10:06 a.m., clinical nurse supervisor (CNS)-B stated R1 and R2's treatment plans did not include their modified diets as they had not considered modified diets as treatments. The licensee's Medication and Treatments policy dated March 2021, indicated the medication and treatment management plan will be completed for all tenants' receiving services prior to initiating services, annually and with change in condition. 10. The medication and treatment management plan will describe the medication or treatment service provided 11. A description of storage of medications 12. Documentation of tenant specific instructions for medications or treatments	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38743	A. BUILDING: _____ B. WING _____	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BODEN SENIOR LIVING APPLE VALLEY	5399 155TH STREET WEST APPLE VALLEY, MN 55124

(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 30 13. Identify the person responsible for ordering supplies and assuring medications are refilled timely 14. The plan will identify which medications or treatments are delegated to unlicensed personnel 15. The plan will identify the procedure for notifying the registered nurse or other licensed staff when a problem arises 16. The plan will identify tenant specific instructions for documenting medication or treatment administration verification 17. The medication and treatment record must be kept current and updated with any changes No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

BODEN SENIOR LIVING - APPLE VA
5399 155TH STREET WEST
Apple Valley, MN 55124
Dakota County
Parcel:

Phone:

License Info

License: HFID 38743

Risk:
License:
Expires on:
CFPM: Marcus Stanley
CFPM #: FM56621; Exp: 2/19/2028

Inspection Info

Report Number: F1004261092
Inspection Type: Full - Single
Date: 3/31/2026 Time: 10:00:00 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 1
Total Priority 2 Orders: 0
Total Priority 3 Orders: 3
Delivery: Emailed

New Order: 3-300C Protection from Contamination: equipment/utensils, consumers
3-304.12F *Priority Level: Priority 3 CFP#: 43*
MN Rule 4626.0275F Discontinue storing food preparation or dispensing utensils in a container of water that is not maintained at 135 degrees F (57 degrees C) and not cleaned when empty.
COMMENT: **FOOD PREPARATION AND DISPENSING UTENSILS FOUND STORED IN A BUCKET OF QUATERNARY AMMONIUM SANITIZER ON THE COOK LINE. DISCONTINUE STORING UTENSILS IN SANITIZER. STAFF STATED UTENSILS WOULD BE REMOVED TO BRING TO THE DISH WASHING AREA. IF UTENSILS ARE SOILED, REMOVE AND PLACE IN DISH AREA OR DESIGNATED DIRTY DISH SPACE.**
***THERE WAS NO OBSERVATION OF STAFF REMOVING THE UTENSILS FOR USE DURING TIME OF INSPECTION, SO NO CONTAMINATION OBSERVED. UTENSILS MUST BE FULLY AIR-DRIED AFTER CONTACTING SANITIZER SOLUTION BEFORE COMING INTO CONTACT WITH FOOD.**
Comply By: 3/31/2026 Originally Issued On: 3/31/2026

! **New Order: 3-500B Microbial Control: hot and cold holding**
3-501.16A2 *Priority Level: Priority 1 CFP#: 22*
MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.
COMMENT: **FOOD ITEMS IN THE ARCTIC AIR STANDING COOLER WERE FOUND TO BE 50*F. AMBIENT AIR TEMPERATURE MEASURED AT 50*F. ALL TCS FOOD ITEMS (MILK, YOGURT) WERE DISCARDED DURING INSPECTION. INSPECTOR INSTRUCTED STAFF NOT TO RE-STOCK UNIT WITH ANY TCS ITEMS UNTIL UNIT HAS BEEN REPAIRED/ADJUSTED AND VERIFIED TO BE ABLE TO MAINTAIN REQUIRED COLD HOLDING TEMPERATURES.**
Comply By: 3/31/2026 Originally Issued On: 3/31/2026

New Order: 4-500 Equipment Maintenance and Operation
4-501.11AB *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.
COMMENT: **ARCTIC AIR STANDING COOLER WAS FOUND HAVE AN AMBIENT AIR TEMPERATURE OF 50*F AND FOOD ITEMS INSIDE MEASURING AT 50*F. HAVE UNIT ADJUSTED/REPAIRED/REPLACED AS NECESSARY TO ENSURE COLD, TCS FOOD ITEMS ARE MAINTAINED AT OR BELOW 41*F.**
Comply By: 3/31/2026 Originally Issued On: 3/31/2026

New Order: 8-500A Embargo/Condemnation
8-501.03MN *Priority Level: Priority 3 CFP#: 58*
MN Rule 4626.1810 The following items are condemned and shall be removed from the establishment immediately:
COMMENT: **TCS FOOD ITEMS FROM THE ARCTIC AIR STANDING COOLER:**
-MILK
-YOGURT
***DISCARDED ON SITE**
Comply By: 3/31/2026 Originally Issued On: 3/31/2026

Food & Beverage General Comment

INSPECTION WAS CONDUCTED BY MOLLY DOUGHERTY (FPLS) IN CONJUNCTION WITH A HEALTH REGULATIONS DIVISION (HRD) SURVEY CONDUCTED BY KASSIE MARKING.

DISCUSSED:
-EMPLOYEE ILLNESS POLICY AND LOG
-HANDWASHING
-PREVENTING BAREHAND CONTACT
-SANITIZER USE AND TEST KITS
-CLEANING/SANITIZING FOOD CONTACT SURFACES AND UTENSILS
-HIGH TEMPERATURE SANITIZING DISH MACHINE TEMPERATURE VERIFICATION
-DATE MARKING PROCEDURES
-THERMOMETER USE AND CALIBRATION
-SERVING A HIGHLY SUSCEPTIBLE POPULATION (NO RAW/UNDERCOOKED ANIMAL FOODS, NO UNPASTEURIZED JUICE, MILK, ETC)
-VOMIT/FECAL INCIDENT CLEAN UP PROCEDURES
-FOOD SOURCE
-RECEIVING DELIVERIES PROCEDURES
-FOOD SERVICE PROCEDURES
-PEST CONTROL
-LOGS (COOLER TEMPERATURE, DISH MACHINE UTENSIL SURFACE TEMPERATURE, SANITIZER CONCENTRATIONS, ETC)
-PHYSICAL FACILITIES AND MAINTENANCE

*REPORT WAS DISCUSSED WITH THE EXECUTIVE CHEF, THE EXECUTIVE DIRECTOR, AND WITH THE NURSE EVALUATOR ON SITE.

*INSPECTOR WILL RETURN FOR A FOLLOW-UP INSPECTION.

*IF ANY RESIDENT COMPLAINS OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE RESIDENT. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.

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 F1004261092 from 3/31/2026

Molly Dougherty

Marcus Stanley

Molly Dougherty,
Public Health Sanitarian 3
651-201-3978
molly.dougherty@state.mn.us

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

Temperature Observations/Recordings

Establishment Info

BODEN SENIOR LIVING - APPLE VA
Apple Valley
County/Group: Dakota County

Inspection Info

Report Number: F1004261092
Inspection Type: Full
Date: 3/31/2026
Time: 10:00:00 AM

Food Temperature: Product/Item/Unit: milk**; Temperature Process:** Cold-Holding
Location: Arctic Air Standing Cooler at 50 Degrees F.
Comment: *discarded
Violation Issued?: Yes

Equipment Temperature: Product/Item/Unit: ambient temperature**; Temperature Process:** Cold-Holding
Location: Arctic Air Standing Cooler at 50 Degrees F.
Comment:
Violation Issued?: Yes

Food Temperature: Product/Item/Unit: sliced tomato**; Temperature Process:** Cold-Holding
Location: Prep Cooler at 38 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: sliced ham**; Temperature Process:** Cold-Holding
Location: Prep Cooler at 40 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: egg salad**; Temperature Process:** Cold-Holding
Location: Prep Cooler at 40 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: mashed potato**; Temperature Process:** Hot-Holding
Location: Steam Table at 173 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: mashed potato**; Temperature Process:** Hot-Holding
Location: Steam Table at 162 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: yogurt**; Temperature Process:** Cold-Holding
Location: Walk-in Cooler at 38 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: tuna salad**; Temperature Process:** Cold-Holding
Location: Walk-in Cooler at 38 Degrees F.
Comment:
Violation Issued?: No

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

Sanitizer Observations/Recordings

Establishment Info

BODEN SENIOR LIVING - APPLE VA
Apple Valley
County/Group: Dakota County

Inspection Info

Report Number: F1004261092
Inspection Type: Full
Date: 3/31/2026
Time: 10:00:00 AM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Dishwashing Area **Equal To** 162 Degrees F.
Comment: *utensil surface temperature
Violation Issued?: No

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** Wiping Cloth Bucket
Location: Cook Line **Equal To** 400 PPM
Comment:
Violation Issued?: No

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** Wiping Cloth Bucket
Location: Prep Area **Equal To** 200 PPM
Comment:
Violation Issued?: No

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

BODEN SENIOR LIVING - APPLE VA
5399 155TH STREET WEST
Apple Valley, MN 55124
Dakota County
Parcel:

Phone:

License Info

License: HFID 38743

Risk:
License:
Expires on:
CFPM: Marcus Stanley
CFPM #: FM56621; Exp: 2/19/2028

Inspection Info

Report Number: F1004261106
Inspection Type: Follow-up - Single
Date: 4/10/2026 Time: 10:15:00 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 1
Total Priority 2 Orders: 0
Total Priority 3 Orders: 2
Delivery: Emailed

! **Previous Order: 3-500B Microbial Control: hot and cold holding**
3-501.16A2 *Priority Level: Priority 1 CFP#: 22*
MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.
COMMENT: **FOOD ITEMS IN THE ARCTIC AIR STANDING COOLER WERE FOUND TO BE 48-49*F. AMBIENT AIR TEMPERATURE MEASURED AT ~48*F. ALL TCS FOOD ITEMS (MILK, CUT MELON, OTHER DAIRY PRODUCTS) WERE DISCARDED DURING INSPECTION. INSPECTOR INSTRUCTED STAFF NOT TO RE-STOCK UNIT WITH ANY TCS ITEMS UNTIL UNIT HAS BEEN REPAIRED/ADJUSTED AND VERIFIED TO BE ABLE TO MAINTAIN REQUIRED COLD HOLDING TEMPERATURES. REISSUED 4/10/26.**
Comply By: 3/31/2026 Originally Issued On: 3/31/2026

Previous Order: 4-500 Equipment Maintenance and Operation
4-501.11AB *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.
COMMENT: **ARCTIC AIR STANDING COOLER WAS FOUND HAVE AN AMBIENT AIR TEMPERATURE OF ~48*F AND FOOD ITEMS INSIDE MEASURING AT 48-49*F. HAVE UNIT ADJUSTED/REPAIRED/REPLACED AS NECESSARY TO ENSURE COLD, TCS FOOD ITEMS ARE MAINTAINED AT OR BELOW 41*F. REISSUED 4/10/26.**
Comply By: 3/31/2026 Originally Issued On: 3/31/2026

Previous Order: 8-500A Embargo/Condemnation
8-501.03MN *Priority Level: Priority 3 CFP#: 58*
MN Rule 4626.1810 The following items are condemned and shall be removed from the establishment immediately:
COMMENT: **TCS FOOD ITEMS FROM THE ARCTIC AIR STANDING COOLER:**
-MILK
-COTTAGE CHEESE
-CUT MELON
-ANY OTHER TCS ITEMS
***DISCARDED ON SITE**
REISSUED 4/10/26.
Comply By: 3/31/2026 Originally Issued On: 3/31/2026

Food & Beverage General Comment

FOLLOW-UP INSPECTION WAS CONDUCTED BY MOLLY DOUGHERTY.

TODAY'S FOLLOW-UP INSPECTION WAS CONDUCTED TO ADDRESS AND CLEAR PREVIOUSLY WRITTEN ORDERS FROM A FULL INSPECTION CONDUCTED ON 3/31/26 AS PART OF A HEALTH REGULATIONS DIVISION (HRD) SURVEY CONDUCTED BY KASSIE MARKING. DURING TODAY'S FOLLOW-UP INSPECTION, 1 OUT OF 4 ORDERS

WERE ABLE TO BE CLEARED FROM THE REPORT.

*INSPECTOR WILL RETURN FOR AN ADDITIONAL FOLLOW-UP INSPECTION.

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 F1004261106 from 4/10/2026

Marcus Stanley

Molly Dougherty

Molly Dougherty,
Public Health Sanitarian 3
651-201-3978
molly.dougherty@state.mn.us

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

Temperature Observations/Recordings

Establishment Info

BODEN SENIOR LIVING - APPLE VA
Apple Valley
County/Group: Dakota County

Inspection Info

Report Number: F1004261106
Inspection Type: Follow-up
Date: 4/10/2026
Time: 10:15:00 AM

Food Temperature: Product/Item/Unit: milk**; Temperature Process:** Cold-Holding
Location: Arctic Air Standing Cooler at 49 Degrees F.
Comment: *discarded
Violation Issued?: Yes

Food Temperature: Product/Item/Unit: cut watermelon**; Temperature Process:** Cold-Holding
Location: Arctic Air Standing Cooler at 48 Degrees F.
Comment:
Violation Issued?: Yes

Equipment Temperature: Product/Item/Unit: ambient temperature**; Temperature Process:** Cold-Holding
Location: Arctic Air Standing Cooler at ~48 Degrees F.
Comment:
Violation Issued?: Yes

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL38743016-0	**Date:** March 31, 2026
Facility Name: BODEN SENIOR LIVING	
Facility Address: 5399 155th W Apple Valley, MN 55124	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

1. Controlled egress locking systems shall: unlock upon activation of either the automatic sprinkler system or automatic fire detection system, unlock upon loss of power controlling the lock, have the capability of being unlocked from the fire command center, a nursing station, or other approved location. Building occupants shall not be required to pass through more than one controlled egress locked door before entering an exit. The procedures for operation of the unlocking system shall be described as part of the fire safety and evacuation plan. All clinical staff shall have the keys, codes, or other means necessary to operate the locking device. [Minn. Stat. 144G.45 subd. 2; MSFC 1010.1.9.7]

   Comments: Facility controlled egress system was not equipped with a separate de-activate button or switch in the fire command center or other approved location to unlock the system.

☒ **TAG IDENTIFICATION: 0810**

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

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

   Comments: The FSEP failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate).