Electronically Delivered

July 14, 2026

Licensee
Harb Services LLC
13752 Zarthan Avenue South
Savage, MN 55378

RE: Project Number(s) SL41111015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial survey on June 10, 2026, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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

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

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

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the

correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers.

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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41111	A. BUILDING: _____ B. WING _____	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARB SERVICES LLC	13752 ZARTHAN AVENUE SOUTH SAVAGE, MN 55378

(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: SL41111015-0 On June 8, 2026, through June 10, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were zero residents; zero residents receiving services at the provisional Assisted Living Facility. 1750: An immediate correction order was written on June 9, 2026, at a level 2/Widespread (F). The licensee took immediate action; however, the correction order remains at F.	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.	
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request	0 460		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41111	A. BUILDING: _____ B. WING _____	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARB SERVICES LLC	13752 ZARTHAN AVENUE SOUTH SAVAGE, MN 55378

(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
0 460	Continued From page 1 assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week. This had the potential to affect all potential 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 of the residents). The findings include:	0 460		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41111	A. BUILDING: _____ B. WING _____	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARB SERVICES LLC	13752 ZARTHAN AVENUE SOUTH SAVAGE, MN 55378

(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
0 460	Continued From page 2 The licensee's discharge resident roster indicated R1 resided in the facility on November 10, 2025, through January 11, 2026. During the entrance conference on June 8, 2026, at 1:49 p.m., owner/assisted living director in residency (O-ALDIR)-A stated R1 was ambulatory and would go to staff to ask for assistance if needed. O-ALDIR-A stated the facility did not have a call light or pendant system the residents could use to summon staff. On May 18, 2026, at approximately 2:00 p.m. during facility tour, the surveyor observed the facility was a two level home with resident rooms on the upper and lower levels. The surveyor did not observe pendants, call light system, or means to request assistance in the residents' rooms. The licensee's Staffing policy dated April 5, 2025, included "Residents are provided with a means to request assistance for health and safety needs 24 hours/day 7 days/week; during night shifts, the home health aide will respond to resident requests for assistance as soon as possible." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 460		
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure,	0 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41111	A. BUILDING: _____ B. WING _____	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARB SERVICES LLC	13752 ZARTHAN AVENUE SOUTH SAVAGE, MN 55378

(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
0 650	Continued From page 3 registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records included all required content for two of two employees (unlicensed personnel (ULP)-D, ULP-F). 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 June 8, 2026, at 2:08 p.m., owner/assisted	0 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41111	A. BUILDING: _____ B. WING _____	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARB SERVICES LLC	13752 ZARTHAN AVENUE SOUTH SAVAGE, MN 55378

(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
0 650	Continued From page 4 living director in residency (O/ALDIR)-B stated the licensee did not have any current residents. The licensee's Discharge Resident/Client Roster printed January 12, 2026, indicated R1 was admitted on November 10, 2025, and was discharged on January 11, 2026. ULP-D ULP-D was hired on November 14, 2025, and provided direct care services to R1 when they resided at the facility. R1's medication administration record (MAR) indicated ULP-D administered oral medications on the following dates: - December 11, 12, 15, 22, 23, 26, 29, 30, 2025; and - January 3, 4, 9, 2026. ULP-D's record included Home Health Aide Supervision: Medication Management form signed by clinical nurse supervisor (CNS)-C on November 12, 2026. ULP-D's employee record lacked evidence of training and competency testing completed by the licensee's RN. ULP-F ULP-F was hired on December 8, 2025, and provided direct care services to R1 when they resided at the facility. R1's medication administration record (MAR) indicated ULP-F administered oral medications on the following dates: - December 6, 7, 10, 13, 17, 31, 2025; and - January 1, 2, 5, 6, 7, 2026.	0 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41111	A. BUILDING: _____ B. WING _____	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARB SERVICES LLC	13752 ZARTHAN AVENUE SOUTH SAVAGE, MN 55378

(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
0 650	Continued From page 5 ULP-F's record included Home Health Aide Supervision: Medication Management form signed by CNS-C on December 7, 2026. ULP-F's employee record lacked evidence of training and competency testing completed by the licensee's RN. On June 9, 2026, at 11:27 a.m., CNS-C stated she trained and competency tested the staff on oral medications since R1 only had oral medications, and she trained staff on medications away from home. CNS-C stated she had not documented the competency testing for any staff. The licensee's Staff Competency policy dated April 5, 2025, indicated "Training and competency evaluations for all unlicensed personnel include the following." "Unlicensed personnel may not work for [licensee] until they have successfully passed the written (at 80%) and demonstration competency evaluation", which included medication administration. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41111	A. BUILDING: _____ B. WING _____	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARB SERVICES LLC	13752 ZARTHAN AVENUE SOUTH SAVAGE, MN 55378

(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
0 660	Continued From page 6 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 establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included documentation of a completed health history and symptom screening, including completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for all six of the employees (owner/assisted living director in residency (O/ALDIR)-A, O/ALDIR-B, clinical nurse supervisor (CNS)-C, unlicensed personnel (ULP)-D, ULP-E, ULP-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's TB facility risk assessment dated	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41111	A. BUILDING: _____ B. WING _____	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARB SERVICES LLC	13752 ZARTHAN AVENUE SOUTH SAVAGE, MN 55378

(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
0 660	Continued From page 7 April 30, 2026, indicated they were a low risk. O/ALDIR-A O/ALDIR-A began providing direct care services on November 10, 2025, when the facility's first resident was admitted. O/ALDIR-A's employee record included: - Annual TB Screening form dated July 25, 2025. The Annual TB Screening included screening of current symptoms but did not include the assessment of the healthcare worker (HCW) history as required; and - a negative chest x-ray dated July 25, 2025; however, there was no evidence of a corresponding positive TST or TB blood test prior to or around the time of the chest x-ray. O/ALDIR-B O/ALDIR-B began providing direct care services on November 10, 2025, when the facility's first resident was admitted. O/ALDIR-B's employee record included: - Annual TB Screening form dated November 6 2025. The Annual TB Screening included screening of current symptoms but did not include the assessment of the healthcare worker (HCW) history as required; and - a negative chest x-ray dated July 9, 2025; however, there was no evidence of a corresponding positive TST or TB blood test prior to or around the time of the chest x-ray. CNS-C CNS-C was hired on November 6, 2025, and began providing direct care services on November 10, 2025, when the facility's first resident was admitted.	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41111	A. BUILDING: _____ B. WING _____	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARB SERVICES LLC	13752 ZARTHAN AVENUE SOUTH SAVAGE, MN 55378

(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
0 660	Continued From page 8 CNS-C's employee record included: - Annual TB Screening form dated November 7, 2025. The Annual TB Screening included screening of current symptoms but did not include the assessment of the healthcare worker (HCW) history as required; and - a negative chest x-ray dated November 7, 2025; however, there was no evidence of a corresponding positive TST or TB blood test prior to or around the time of the chest x-ray. ULP-D ULP-D was hired on November 14, 2025, and provided direct care services to the licensee's resident. ULP-D's employee record included: - Annual TB Screening form dated November 14, 2025. The Annual TB Screening included screening of current symptoms but did not include the assessment of the healthcare worker (HCW) history as required; and - negative results for a single TST read on November 8, 2025; however ULP-D's record did not include evidence of a second TST as required. ULP-E ULP-E was hired on November 7, 2025, and began providing direct care services on November 10, 2025, when the facility's first resident was admitted. ULP-E's employee record included: - Annual TB Screening form dated November 9, 2025. The Annual TB Screening included screening of current symptoms but did not include the assessment of the healthcare worker (HCW) history as required; and - negative results for a single TST read on	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41111	A. BUILDING: _____ B. WING _____	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARB SERVICES LLC	13752 ZARTHAN AVENUE SOUTH SAVAGE, MN 55378

(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
0 660	Continued From page 9 October 27, 2025; however ULP-E's record did not include evidence of a second TST as required. ULP-F ULP-F was hired on December 8, 2025, provided direct care services to the licensee's resident. ULP-F's employee record included: - Annual TB Screening form dated December 8, 2025. The Annual TB Screening included screening of current symptoms but did not include the assessment of the healthcare worker (HCW) history as required; and - negative results for a single TST read on November 10, 2025; however ULP-E's record did not include evidence of a second TST as required. On June 8, 2026, at 3:05 p.m., CNS-C stated she was unaware the TB screening form used did not have all the required information and was unaware of the need for documentation of the positive test result before or around the time of the chest x-ray. CNS-C further stated staff tested with TST should have had two steps. The licensee's Tuberculosis Screening/Prevention policy dated April 5, 2025, included: 1. Employees receive baseline TB screening upon hire to test for infection with M. tuberculosis. 2. Baseline screening includes an assessment for TB history and current TB symptoms. 3. An employee's history of BCG vaccination will be disregarded when administering and interpreting TST results. 4. The baseline test may be either TST (2-step) or BAMT. 5. If the first-step TST is negative, the	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41111	A. BUILDING: _____ B. WING _____	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARB SERVICES LLC	13752 ZARTHAN AVENUE SOUTH SAVAGE, MN 55378

(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
0 660	Continued From page 10 second-step TST will be administered 1--3 weeks after the first TST result was read. 6. If the first and second-step TST results are both negative, the person is classified as not infected with M. tuberculosis. Additional TB screening is not necessary unless an exposure to M. tuberculosis occurs. 7. Written documentation for all TST results includes the mm induration, the interpretation (either positive or negative), the date read and a signature on letterhead. 8. Employees with written documentation of a previous positive TST or BAMT do not need a repeat TST or BAMT: · Assess for current TB symptoms · If they provide written documentation of the results of a chest x-ray indicating no active TB disease that is dated after the date of the positive TST or TB blood test result, they do not need another chest x-ray at the time of hire. · If they do not have the written documentation from above, they must receive a chest x-ray to exclude a diagnosis of infectious TB disease before having direct patient contact. · Assess these employees annually for current TB symptoms. Instruct them to seek medical evaluation if TB symptoms develop at any time. · After the baseline chest x-ray is performed and the result is documented, repeat x-rays are not needed unless symptoms or signs of TB disease develop or a clinician recommends a repeat chest radiograph. 9. Employees with a verbal, but undocumented, history of a previous positive TST or BAMT will undergo the same screening process as those without previous positive results. Staff should be encouraged to keep copies of the results of the TB screening, for future use.	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41111	A. BUILDING: _____ B. WING _____	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARB SERVICES LLC	13752 ZARTHAN AVENUE SOUTH SAVAGE, MN 55378

(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
0 660	Continued From page 11 The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated an employee may begin working with patients 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 (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record." The Regulations include a Baseline TB Screening Tool for Health Care Workers (HCWs) which indicates "Baseline TB screening includes three components: (1) Assessing for current symptoms of active TB disease *and* (2) Assessing HCW's history *and* (3) Testing for the presence of infection with Mycobacterium tuberculosis by administering either a single TB blood test or a two-step TST." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
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:	0 950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41111	A. BUILDING: _____ B. WING _____	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARB SERVICES LLC	13752 ZARTHAN AVENUE SOUTH SAVAGE, MN 55378

(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
0 950	Continued From page 12 "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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer the resident the opportunity to identify a designated representative in writing with the required statutory language for one of one resident (R1). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41111	A. BUILDING: _____ B. WING _____	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARB SERVICES LLC	13752 ZARTHAN AVENUE SOUTH SAVAGE, MN 55378

(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
0 950	Continued From page 13 The findings include: R1 was admitted to the facility on November 10, 2025. R1's contract was signed on November 10, 2025. The contract did not 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. R1's record did not contain a separate page from the contract the verbatim required statement; "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." On June 9, 2026, at 2:26 p.m., owner/assisted living director in residency (O/ALDIR)-A stated they were unaware of the designated representative required verbatim statement that was to be provided on a separate page from the contract or that the contract should have had a place to list a designate a representative and a space to check if declining a designative representative. No further information was provided.	0 950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41111	A. BUILDING: _____ B. WING _____	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARB SERVICES LLC	13752 ZARTHAN AVENUE SOUTH SAVAGE, MN 55378

(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
0 950	Continued From page 14 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
01320 SS=F	144G.60 Subd. 4 (a) Unlicensed personnel (a) Unlicensed personnel providing assisted living services must have: (1) successfully completed a training and competency evaluation appropriate to the services provided by the facility and the topics listed in section 144G.61, subdivision 2, paragraph (a); or (2) demonstrated competency by satisfactorily completing a written or oral test on the tasks the unlicensed personnel will perform and on the topics listed in section 144G.61, subdivision 2, paragraph (a); and successfully demonstrated competency on topics in section 144G.61, subdivision 2, paragraph (a), clauses (5), (7), and (8), by a practical skills test. Unlicensed personnel who only provide assisted living services listed in section 144G.08, subdivision 9, clauses (1) to (5), shall not perform delegated nursing or therapy tasks. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas prior to providing services, for all five employees (owner/assisted living director in residency (O/ALDIR)-A, ALDIR-B, unlicensed personnel (ULP)-D, ULP-E, ULP-F). 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	01320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41111	A. BUILDING: _____ B. WING _____	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARB SERVICES LLC	13752 ZARTHAN AVENUE SOUTH SAVAGE, MN 55378

(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
01320	Continued From page 15 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 June 8, 2026, at 2:08 p.m., O/ALDIR-B stated the licensee did not have any current residents. The licensee's Discharge Resident/Client Roster printed January 12, 2026, indicated R1 was admitted on November 10, 2025, and was discharged on January 11, 2026. O/ALDIR-A was hired on May 22, 2024, and began providing direct care services to the licensee's one resident (R1) on November 10, 2025. R1's medication administration record (MAR) indicated O/ALDIR-A administered oral medications on the following dates: - November 15, 16, 19, 20, 22, 26, 27, 29, 30, 2025; - December 1, 2, 9, 14, 16, 28, 2025; and - January 5, 8, 2026. O/ALDIR-A's employee record lacked evidence of training and/or competency testing for the following required topics: - appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; - standby assistance techniques and how to	01320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41111	A. BUILDING: _____ B. WING _____	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARB SERVICES LLC	13752 ZARTHAN AVENUE SOUTH SAVAGE, MN 55378

(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
01320	Continued From page 16 perform them; - communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family. O/ALDIR-B O/ALDIR-B began providing direct care services on November 10, 2025, when the licensee's first resident was admitted. O/ALDIR-B's employee record lacked evidence of training and/or competency testing for the following required topics: - documentation requirements for all services provided; - reports of changes in the resident's condition to the supervisor designated by the facility; - training on the prevention of falls; - appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; - standby assistance techniques and how to perform them; - basic nutrition, meal preparation, food safety, and assistance with eating; - preparation of modified diets as ordered by a licensed health professional; - communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; ULP-D	01320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41111	A. BUILDING: _____ B. WING _____	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARB SERVICES LLC	13752 ZARTHAN AVENUE SOUTH SAVAGE, MN 55378

(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
01320	Continued From page 17 ULP-D was hired on November 14, 2025, and provided direct care services to R1 when they resided at the facility. R1's medication administration record (MAR) indicated ULP-D administered oral medications on the following dates: - December 11, 12, 15, 22, 23, 26, 29, 30, 2025; and - January 3, 4, 9, 2026. ULP-D's employee record lacked evidence of training and/or competency testing for the following required topics: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (13) understanding appropriate boundaries between staff and residents and the resident's	01320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41111	A. BUILDING: _____ B. WING _____	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARB SERVICES LLC	13752 ZARTHAN AVENUE SOUTH SAVAGE, MN 55378

(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
01320	Continued From page 18 family ULP-E ULP-E was hired on November 7, 2025, and began providing direct care services on November 10, 2025, when the licensee's first resident was admitted. ULP-E's employee record lacked evidence of training and/or competency testing for the following required topics: (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; and (13) understanding appropriate boundaries between staff and residents and the resident's	01320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41111	A. BUILDING: _____ B. WING _____	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARB SERVICES LLC	13752 ZARTHAN AVENUE SOUTH SAVAGE, MN 55378

(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
01320	Continued From page 19 family. ULP-F ULP-F was hired on December 8, 2025, and provided direct care services to R1 when they resided at the facility. R1's medication administration record (MAR) indicated ULP-F administered oral medications on the following dates: - December 6, 7, 10, 13, 17, 31, 2025; and - January 1, 2, 5, 6, 7, 2026. ULP-F's lacked employee record lacked evidence of training and/or competency testing for the following required topics: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences,	01320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41111	A. BUILDING: _____ B. WING _____	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARB SERVICES LLC	13752 ZARTHAN AVENUE SOUTH SAVAGE, MN 55378

(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
01320	Continued From page 20 cultural background, and family; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. On June 8, 2026, at 11:08 a.m., O/ALDIR-A stated she used the electronic training and new hires would be assigned a grouping of trainings. She was unaware that staff had not completed all the trainings. On June 8, 2026, at 11:27 a.m., clinical nurse supervisor (CNS)-C stated the only competency testing completed was for medications. The licensee's Staff Competency policy dated April 5, 2025, included the following: "3. Training and competency evaluations for all unlicensed personnel include the following. Refer to the Competency Manual for criteria. Unlicensed personnel may not work for [licensee] Services until they have successfully passed the written (at 80%) and demonstration competency evaluation. a. Documentation requirements for all services provided b. Reports of changes in the resident's condition to the supervisor designated by the assisted living provider c. Basic infection control, including blood-borne pathogens d. Maintenance of a clean and safe environment e. Appropriate and safe techniques in personal hygiene and grooming, including hair care and bathing; care of teeth, gums and oral prosthetic devices; care and use of hearing aids; and	01320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41111	A. BUILDING: _____ B. WING _____	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARB SERVICES LLC	13752 ZARTHAN AVENUE SOUTH SAVAGE, MN 55378

(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
01320	Continued From page 21 dressing and assisting with toileting. f. Training on the prevention of falls for providers working with the elderly or those at risk of falls g. Standby assistance techniques and how to perform them h. Medication, exercise and treatment reminders i. Basic nutrition, meal preparation and preparation of modified diets as ordered by a licensed health professional, food safety and assistance with eating j. Communication skills that include preserving the dignity of the resident and showing respect for the resident's preferences, cultural background and family k. Awareness of confidentiality and privacy l. Understanding appropriate boundaries between staff, residents and the resident's family m. Procedures to utilize in handling various emergency situations n. Awareness of commonly used health technology equipment and assistive devices c. The following topics must be completed by a practical skills test i. Appropriate and safe techniques in personal hygiene and grooming, including bathing, hair care, oral hygiene (teeth, gums and oral prosthetics), care and use of hearing aids, dressing and toileting No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01320		
01330 SS=F	144G.60 Subd. 4 (b) Unlicensed personnel (b) Unlicensed personnel performing delegated	01330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41111	A. BUILDING: _____ B. WING _____	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARB SERVICES LLC	13752 ZARTHAN AVENUE SOUTH SAVAGE, MN 55378

(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
01330	Continued From page 22 nursing tasks in an assisted living facility must: (1) have successfully completed training and demonstrated competency by successfully completing a written or oral test of the topics in section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform; (2) satisfy the current requirements of Medicare for training or competency of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or 484.36; or (3) have, before April 19, 1993, completed a training course for nursing assistants that was approved by the commissioner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas prior to providing services for all five employees (owner/assisted living director in residency (O/ALDIR)-A, ALDIR-B, unlicensed personnel (ULP)-D, ULP-E, ULP-F). 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:	01330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41111	A. BUILDING: _____ B. WING _____	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARB SERVICES LLC	13752 ZARTHAN AVENUE SOUTH SAVAGE, MN 55378

(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
01330	Continued From page 23 On June 8, 2026, at 2:08 p.m., O/ALDIR-B stated the licensee did not have any current residents. The licensee's Discharge Resident/Client Roster printed January 12, 2026, indicated R1 was admitted on November 10, 2025, and was discharged on January 11, 2026. O/ALDIR-A was hired on May 22, 2024, and began providing direct care services to the licensee's one resident (R1) on November 10, 2025. R1's medication administration record (MAR) indicated O/ALDIR-A administered oral medications on the following dates: - November 15, 16, 19, 20, 22, 26, 27, 29, 30, 2025; - December 1, 2, 9, 14, 16, 28, 2025; and - January 5, 8, 2026. O/ALDIR-A's employee record lacked evidence of training and/or competency testing for the following required topics: (3) reading and recording temperature, pulse, and respirations of the resident; (5) safe transfer techniques and ambulation; and (6) range of motioning and positioning. O/ALDIR-B O/ALDIR-B began providing direct care services on November 10, 2025, when the licensee's first resident was admitted. O/ALDIR-B's employee record lacked evidence of training and/or competency testing for the following required topics: (1) observing, reporting, and documenting	01330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41111	A. BUILDING: _____ B. WING _____	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARB SERVICES LLC	13752 ZARTHAN AVENUE SOUTH SAVAGE, MN 55378

(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
01330	Continued From page 24 resident status; (3) reading and recording temperature, pulse, and respirations of the resident; (5) safe transfer techniques and ambulation; and (6) range of motioning and positioning. ULP-D ULP-D was hired on November 14, 2025, and provided direct care services to R1 when they resided at the facility. R1's medication administration record (MAR) indicated ULP-D administered oral medications on the following dates: - December 11, 12, 15, 22, 23, 26, 29, 30, 2025; and - January 3, 4, 9, 2026. ULP-D's employee record lacked evidence of training and/or competency testing for the following required topics: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning ULP-E ULP-E was hired on November 7, 2025, and began providing direct care services on November 10, 2025, when the licensee's first	01330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41111	A. BUILDING: _____ B. WING _____	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARB SERVICES LLC	13752 ZARTHAN AVENUE SOUTH SAVAGE, MN 55378

(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
01330	Continued From page 25 resident was admitted. ULP-E's employee record lacked evidence of training and/or competency testing for the following required topics: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; and (6) range of motioning and positioning ULP-F ULP-F was hired on December 8, 2025, and provided direct care services to R1 when they resided at the facility. R1's medication administration record (MAR) indicated ULP-F administered oral medications on the following dates: - December 6, 7, 10, 13, 17, 31, 2025; and - January 1, 2, 5, 6, 7, 2026. ULP-F's lacked employee record lacked evidence of training and/or competency testing for the following required topics: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and	01330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41111	A. BUILDING: _____ B. WING _____	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARB SERVICES LLC	13752 ZARTHAN AVENUE SOUTH SAVAGE, MN 55378

(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
01330	Continued From page 26 respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; and (6) range of motioning and positioning On June 8, 2026, at 11:08 a.m., O/ALDIR-A stated she used the electronic training and new hires would be assigned a grouping of trainings. She was unaware that staff had not completed all the trainings. On June 8, 2026, at 11:27 a.m., clinical nurse supervisor (CNS)-C stated the only competency testing completed was for medications. The licensee's Staff Competency policy dated April 5, 2025, included the following: c. The following topics must be completed by a practical skills test i. Appropriate and safe techniques in personal hygiene and grooming, including bathing, hair care, oral hygiene (teeth, gums and oral prosthetics), care and use of hearing aids, dressing and toileting ii. Safe transfer techniques and ambulation iii. Range of motion and positioning iv. Reading and recording temperature, pulse and respirations v. Administration of medications and treatments, as required vi. Other delegated tasks No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41111	A. BUILDING: _____ B. WING _____	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARB SERVICES LLC	13752 ZARTHAN AVENUE SOUTH SAVAGE, MN 55378

(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
01440	Continued From page 27	01440		
01440 SS=F	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 interview and record review, the licensee failed to ensure the registered nurse (RN) conducted direct supervision of staff performing delegated nursing or therapy tasks within 30 days of first providing those services for three of three employees (owner/assisted living director in residency (O/ALDIR)-A, unlicensed personnel (ULP)-D, ULP-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01440		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41111	A. BUILDING: _____ B. WING _____	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARB SERVICES LLC	13752 ZARTHAN AVENUE SOUTH SAVAGE, MN 55378

(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
01440	Continued From page 28 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 June 8, 2026, at 2:08 p.m., O/ALDIR-B stated the licensee did not have any current residents. The licensee's Discharge Resident/Client Roster printed January 12, 2026, indicated R1 was admitted on November 10, 2025, and was discharged on January 11, 2026. O/ALDIR-A was hired on May 22, 2024, and began providing direct care services to the licensees one resident (R1) on November 10, 2025. R1's medication administration record (MAR) indicated O/ALDIR-A administered oral medications on the following dates: - November 15, 16, 19, 20, 22, 26, 27, 29, 30, 2025; - December 1, 2, 9, 14, 16, 28, 2025; and - January 5, 8, 2026. O/ALDIR-A's employee record lacked evidence a 30 day supervision of delegated nursing services was completed. ULP-D ULP-D was hired on November 14, 2025, and provided direct care services to R1 when they resided at the facility.	01440		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41111	A. BUILDING: _____ B. WING _____	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARB SERVICES LLC	13752 ZARTHAN AVENUE SOUTH SAVAGE, MN 55378

(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
01440	Continued From page 29 R1's MAR indicated ULP-D administered oral medications on the following dates: - December 11, 12, 15, 22, 23, 26, 29, 30, 2025; and - January 3, 4, 9, 2026. ULP-D's record included Home Health Aide Supervision: Medication Management form signed by CNS-C on November 12, 2025, (two days before ULP-D's listed hire date). ULP-D's employee record lacked evidence a 30 day supervision of delegated nursing services was completed. ULP-F ULP-F was hired on December 8, 2025, and provided direct care services to R1 when they resided at the facility. R1's medication administration record (MAR) indicated ULP-F administered oral medications on the following dates: - December 6, 7, 10, 13, 17, 31, 2025; and - January 1, 2, 5, 6, 7, 2026. ULP-F's record included Home Health Aide Supervision: Medication Management form signed by CNS-C on December 7, 2025, (one day before ULP-F's listed hire date). ULP-F's employee record lacked evidence lacked evidence a 30 day supervision of delegated nursing services was completed. On June 9, 2026, at 11:27 a.m., CNS-C stated she used the Home Health Aide Supervision form to document training. CNS-C stated being unaware the 30 day supervision of delegated services was a separate requirement.	01440		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41111	A. BUILDING: _____ B. WING _____	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARB SERVICES LLC	13752 ZARTHAN AVENUE SOUTH SAVAGE, MN 55378

(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
01440	Continued From page 30 The licensee's Supervision: Unlicensed Staff policy dated April 5, 2025, included: "Direct supervision of home health aides performing delegated tasks will be provided within 30 days after the individual begins working for the assisted living provider and thereafter as needed based on performance." No further information was 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 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;	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41111	A. BUILDING: _____ B. WING _____	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARB SERVICES LLC	13752 ZARTHAN AVENUE SOUTH SAVAGE, MN 55378

(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
01470	Continued From page 31 (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 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 interview and record review, the licensee failed to ensure orientation including all the required topics was completed for all six	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41111	A. BUILDING: _____ B. WING _____	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARB SERVICES LLC	13752 ZARTHAN AVENUE SOUTH SAVAGE, MN 55378

(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
01470	Continued From page 32 employees (owner/assisted living director in residency (O/ALDIR)-A, ALDIR-B, clinical nurse supervisor (CNS)-C, unlicensed personnel (ULP)-D, ULP-E, ULP-F). 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 June 8, 2026, at 2:08 p.m., O/ALDIR-B stated the licensee did not have any current residents. The licensee's Discharge Resident/Client Roster printed January 12, 2026, indicated R1 was admitted on November 10, 2025, and was discharged on January 11, 2026. O/ALDIR-A was hired on May 22, 2024, and began providing direct care services to the licensees one resident (R1) on November 10, 2025. R1's medication administration record (MAR) indicated O/ALDIR-A administered oral medications on the following dates: - November 15, 16, 19, 20, 22, 26, 27, 29, 30, 2025; - December 1, 2, 9, 14, 16, 28, 2025; and - January 5, 8, 2026. O/ALDIR-A's employee record lacked evidence of orientation for the following required topics:	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41111	A. BUILDING: _____ B. WING _____	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARB SERVICES LLC	13752 ZARTHAN AVENUE SOUTH SAVAGE, MN 55378

(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
01470	Continued From page 33 - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. O/ALDIR-B O/ALDIR-B began providing direct care services on November 10, 2025, when the licensee's first resident was admitted. O/ALDIR-B's employee record lacked evidence of orientation for the following required topics: - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. CNS-C CNS-C was hired on November 6, 2025, and began providing direct care services on November 10, 2025, when the licensee's first resident was admitted. CNS-C's employee record lacked evidence of orientation for the following required topics: - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; and - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. ULP-D ULP-D was hired on November 14, 2025, and provided direct care services to R1 when they resided at the facility. R1's medication administration record (MAR) indicated ULP-D administered oral medications	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41111	A. BUILDING: _____ B. WING _____	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARB SERVICES LLC	13752 ZARTHAN AVENUE SOUTH SAVAGE, MN 55378

(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
01470	Continued From page 34 on the following dates: - December 11, 12, 15, 22, 23, 26, 29, 30, 2025; and - January 3, 4, 9, 2026. ULP-D's employee record lacked evidence of orientation for the following required topics: - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; and - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. ULP-E ULP-E was hired on November 7, 2025, and began providing direct care services on November 10, 2025, when the licensee's first resident was admitted. ULP-E's employee record lacked evidence of orientation for the following required topics: - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; and - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. ULP-F ULP-F was hired on December 8, 2025, and provided direct care services to R1 when they resided at the facility. R1's medication administration record (MAR) indicated ULP-F administered oral medications	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41111	A. BUILDING: _____ B. WING _____	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARB SERVICES LLC	13752 ZARTHAN AVENUE SOUTH SAVAGE, MN 55378

(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
01470	Continued From page 35 on the following dates: - December 6, 7, 10, 13, 17, 31, 2025; and - January 1, 2, 5, 6, 7, 2026. ULP-F's lacked employee record lacked evidence of orientation for the following required topics: - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; and - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On June 8, 2026, at 11:08 a.m., O/ALDIR-A stated she used the electronic training and new hires would be assigned a grouping of trainings. She was unaware the required orientation included review of policies and person centered care. The licensee's Staff Orientation and Education policy dated April 5, 2025, indicated: Orientation topics will include: c. Introduction to and review of the organization's policies and procedures related to the provision of assisted living services by the individual staff person g. The principles of person-centered planning and service delivery and how they apply to direct support services provided by staff No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01530 SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De-	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41111	A. BUILDING: _____ B. WING _____	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARB SERVICES LLC	13752 ZARTHAN AVENUE SOUTH SAVAGE, MN 55378

(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 36 (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the 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;	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41111	A. BUILDING: _____ B. WING _____	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARB SERVICES LLC	13752 ZARTHAN AVENUE SOUTH SAVAGE, MN 55378

(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 37 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure direct care staff completed the required eight hours of dementia care training and/or the required two hours of initial training on mental illness and de-escalation topics for all six employees (owner/assisted living director in residency (O/ALDIR)-A, ALDIR-B, clinical nurse supervisor (CNS)-C, unlicensed personnel (ULP)-D, ULP-E, ULP-F). 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 June 8, 2026, at 2:08 p.m., O/ALDIR-B stated the licensee did not have any current residents. The licensee's Discharge Resident/Client Roster printed January 12, 2026, indicated R1 was admitted on November 10, 2025, and was discharged on January 11, 2026. O/ALDIR-A was hired on May 22, 2024, and began providing direct care services to the licensee's one resident (R1) on November 10, 2025.	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41111	A. BUILDING: _____ B. WING _____	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARB SERVICES LLC	13752 ZARTHAN AVENUE SOUTH SAVAGE, MN 55378

(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 38 R1's medication administration record (MAR) indicated O/ALDIR-A administered oral medications on the following dates: - November 15, 16, 19, 20, 22, 26, 27, 29, 30, 2025; - December 1, 2, 9, 14, 16, 28, 2025; and - January 5, 8, 2026. O/ALDIR-A's employee record lacked evidence of completing any dementia or mental health training. O/ALDIR-B O/ALDIR-B began providing direct care services on November 10, 2025, when the licensee's first resident (R1) was admitted. O/ALDIR-B's employee record lacked evidence of completing any dementia or mental health training. CNS-C CNS-C was hired on November 6, 2025, and began providing direct care services on November 10, 2025, when the licensee's first resident (R1) was admitted. CNS-C's employee record lacked evidence of completing any dementia or mental health training. ULP-D ULP-D was hired on November 14, 2025, and provided direct care services to R1 when they resided at the facility. R1's MAR indicated ULP-D administered oral medications on the following dates:	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41111	A. BUILDING: _____ B. WING _____	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARB SERVICES LLC	13752 ZARTHAN AVENUE SOUTH SAVAGE, MN 55378

(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 39 - December 11, 12, 15, 22, 23, 26, 29, 30, 2025; and - January 3, 4, 9, 2026. ULP-D's employee record lacked evidence any dementia training had been completed. ULP-D had completed 1.5 hours of mental illness training, which did not include de-escalation techniques. ULP-E ULP-E was hired on November 7, 2025, and began providing direct care services on November 10, 2025, when the facilities first resident was admitted. ULP-E's employee record lacked evidence any dementia or mental health training had been completed. ULP-F ULP-F was hired on December 8, 2025, and provided direct care services to R1 when they resided at the facility. R1's MAR indicated ULP-F administered oral medications on the following dates: - December 6, 7, 10, 13, 17, 31, 2025; and - January 1, 2, 5, 6, 7, 2026. ULP-F's lacked employee record lacked evidence of completing any dementia or mental health training. On June 8, 2026, at 11:08 a.m., O/ALDIR-A stated she was unaware the dementia training had to be completed since they were not a dementia care facility.	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41111	A. BUILDING: _____ B. WING _____	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARB SERVICES LLC	13752 ZARTHAN AVENUE SOUTH SAVAGE, MN 55378

(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 40 The licensee's Dementia Education policy dated April 5, 2025, included: Supervisors of direct-care staff will have at least eight (8) hours of initial education** within 120 working hours of employment start date in the following topics: a. An explanation of Alzheimer's Disease and other dementias b. Assistance with activities of daily living (ADL's) c. Problem solving with challenging behaviors d. Communication skills e. Person-centered planning and service delivery No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
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	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41111	A. BUILDING: _____ B. WING _____	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARB SERVICES LLC	13752 ZARTHAN AVENUE SOUTH SAVAGE, MN 55378

(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
01640	Continued From page 41 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 interview and record review, the licensee failed to revise the service plan when changes to the resident (R1) services occurred. 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 June 8, 2026, at 2:08 p.m., owner/assisted living director in residency (O/ALDIR)-B stated the licensee did not have any current residents. The licensee's Discharge Resident/Client Roster printed January 12, 2026, indicated R1 was admitted on November 10, 2025, and was discharged on January 11, 2026. R1's Service Recap Summary dated December 2025, indicated behavior management for agitation was added as a service on December 10, 2025. R1's service plan signed November 14, 2025, did not include behavior management.	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41111	A. BUILDING: _____ B. WING _____	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARB SERVICES LLC	13752 ZARTHAN AVENUE SOUTH SAVAGE, MN 55378

(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
01640	Continued From page 42 On June 8, 2026, at 11:08 a.m., O/ALDIR-A stated she was unaware R1 needed to sign a new service agreement when behavior management services were added. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01750 SS=F	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, 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 records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure one of three employees (owner/assisted living director in residency (O/ALDIR)-A) completed training and/or competency evaluations for medication administration with a registered nurse (RN) prior to administering medications. This resulted in an immediate correction order identified on June 9, 2026.	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41111	A. BUILDING: _____ B. WING _____	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARB SERVICES LLC	13752 ZARTHAN AVENUE SOUTH SAVAGE, MN 55378

(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
01750	Continued From page 43 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 June 8, 2026, at 2:08 p.m., O/ALDIR-B stated the licensee did not have any current residents. The licensee's Discharge Resident/Client Roster printed January 12, 2026, indicated R1 was admitted on November 10, 2025, and was discharged on January 11, 2026. O/ALDIR-A was hired on May 22, 2024, and began providing direct care services to the licensees one resident (R1) on November 10, 2025. R1's medication administration record (MAR) indicated O/ALDIR-A administered oral medications on the following dates: - November 15, 16, 19, 20, 22, 26, 27, 29, 30, 2025; - December 1, 2, 9, 14, 16, 28, 2025; and - January 5, 8, 2026. O/ALDIR-A's employee record indicated they had completed a Medication Administration course through an outside service on February 22, 2025. O/ALDIR-A's employee record indicated they had completed online training including the following: - Medication Administration - Overview on	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41111	A. BUILDING: _____ B. WING _____	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARB SERVICES LLC	13752 ZARTHAN AVENUE SOUTH SAVAGE, MN 55378

(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
01750	Continued From page 44 November 9, 2025; and - Medication Administration - Routes and Medication Administration - Nebulizers and Inhalers on December 1, 2025. O/ALDIR-A's employee record lacked evidence of training and competency testing completed by the licensee's RN. On June 9, 2026, at 11:08 a.m. O/ALDIR-A stated she had taken the course through an outside service and thought that was sufficient. O/ALDIR-A stated she was not trained or competency tested by clinical nurse supervisor (CNS)-C and was unaware it was required since she had the other certificate from the outside service. On June 9, 2026, at 11:27 a.m. CNS-C stated she had not completed medication training and competency testing with O/ALDIR-A since she had completed a course through the outside service. The licensee's Staff Competency policy dated April 5, 2025, indicated "3. Training and competency evaluations for all unlicensed personnel include the following." "Unlicensed personnel may not work for [licensee] until they have successfully passed the written (at 80%) and demonstration competency evaluation", which included medication administration. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate The licensee took immediate action to mitigate risk; however, the scope and level remains at F.	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41111	A. BUILDING: _____ B. WING _____	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARB SERVICES LLC	13752 ZARTHAN AVENUE SOUTH SAVAGE, MN 55378

(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
01820	Continued From page 45	01820		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure current written or electronically recorded prescriptions were in the licensee's one resident's (R1) record. 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 June 8, 2026, at 2:08 p.m., owner/assisted living director in residency (O/ALDIR)-B stated the licensee did not have any current residents. The licensee's Discharge Resident/Client Roster printed January 12, 2026, indicated R1 was admitted on November 10, 2025, and was discharged on January 11, 2026. R1's medication administration record for January 2026, included: - Vitamin C 500 mg daily (vitamin supplement)	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41111	A. BUILDING: _____ B. WING _____	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARB SERVICES LLC	13752 ZARTHAN AVENUE SOUTH SAVAGE, MN 55378

(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
01820	Continued From page 46 - vitamin B12 500 mcg 2 tablets daily (supplement) - losartan 50 mg/hydrochlorothiazide 12.5 mg daily (blood pressure) - multivitamin one daily (supplement) - elderberry supplement one daily (supplement) - olanzapine 5 mg daily at bedtime (antipsychotic) R1's Discharge Medication Reconciliation report dated December 27, 2025, included: - Losartan 50 mg daily - do not continue - Valsartan 80 mg by mouth daily - hydrochlorothiazide 12.5 mg daily - amlodipine 10 mg daily Upon review, the surveyor noted the following: - the physician orders did not include vitamin C, Vitamin B12, multivitamin, or elderberry. - losartan was discontinued on the physician orders but continued to be administered as a combination medication with the hydrochlorothiazide - valsartan was not being administered according to the orders - amlodipine was not being administered according to the orders. On June 9, 2026, at 2:46 p.m., clinical nurse supervisor (CNS)-C stated the pharmacy accesses the electronic record and enters the orders. Medication changes are completed by them (pharmacy) and she checks and approves them. Hard copies of the prescriptions are not in R1's file for changes made. On June 12, 2026, at 1:02 p.m., the surveyor received an email from CNS-C. CNS-C indicated the fax only saved for 30 days so she was unable to access any faxed clarification orders.	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41111	A. BUILDING: _____ B. WING _____	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARB SERVICES LLC	13752 ZARTHAN AVENUE SOUTH SAVAGE, MN 55378

(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
01820	Continued From page 47 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		

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

Harb Services LLC
13752 ZARTHAN AVENUE SOUTH
Savage, MN 55378
Scott County
Parcel:

Phone:

License Info

License: HFID 41111

Risk:
License:
Expires on:
CFPM: Dek Ahmed Farah
CFPM #: FM123698; Exp: 3/24/2027

Inspection Info

Report Number: F1047261147
Inspection Type: Full - Single
Date: 6/9/2026 Time: 10:00 am
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery:

No orders were issued for this inspection report.

Food & Beverage General Comment

The inspection was completed with the operator and reviewed with MDH Nurse Evaluator S. Haag.

The establishment has a residential kitchen and serves food that is prepared that day. Currently there are no residents at this facility. The kitchen has wood cabinets, laminate floor, painted walls, solid counter top, and a painted ceiling.

A two basin sink is located in the kitchen. One sink basin is designated for hand washing. A residential dish machine is located in the kitchen.

Facility did not have any TCS foods at time of inspection.

Discussed need for operator to finish the state CFPM process, as current CFPM is contracted for the facility but is not on permanent staff.

Discussed hand washing, ware washing, staff illness policy, temperature control, final cook temperatures, cleaning, serving highly susceptible populations, and food handling procedures.

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 F1047261147 from 6/9/2026

Amina Abdulle
Operator

Holly Sievers,
Public Health Sanitarian 3
651-201-5946
holly.sievers@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

Harb Services LLC
Savage
County/Group: Scott County

Inspection Info

Report Number: F1047261147
Inspection Type: Full
Date: 6/9/2026
Time: 10:00 am

Equipment Temperature: Product/Item/Unit: Ambient**; Temperature Process:** Ambient Air
Location: Refrigerator 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

Harb Services LLC
Savage
County/Group: Scott County

Inspection Info

Report Number: F1047261147
Inspection Type: Full
Date: 6/9/2026
Time: 10:00 am

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Kitchen **Greater Than** 180 Degrees F.
Comment:
Violation Issued?: No