Electronically Delivered

July 10, 2026

Licensee
Greatercare Facilities LLC
6576 Falstaff Terrace
Woodbury, MN 55125

RE: Project Number(s) SL35718016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 3, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00

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

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

The correction order documentation should include the following:

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

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

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

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

factor.

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

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

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

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,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35718	A. BUILDING: _____ B. WING _____	06/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREATERCARE FACILITIES LLC	6576 FALSTAFF TERRACE WOODBURY, MN 55125

(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: SL35718016-0 On June 1, 2026, through June 3, 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 four (4) residents; 4 receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 450 SS=F	144G.41 Subdivision 1 Minimum requirements All assisted living facilities shall:	0 450		

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0 450	Continued From page 1 (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure utilization of person-centered planning and service delivery process for each resident receiving services. This had the potential to affect all 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: R1 R1 was admitted to the licensee on April 24, 2023, with diagnoses including type 2 diabetes mellitus, schizoaffective disorder, antisocial personality disorder, and depression.	0 450		

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0 450	Continued From page 2 R1's Service Plan signed November 27, 2025, indicated R1 received services which included medication administration, activity assistance, bathing reminder, behavior documentation, behavior management, grooming, housekeeping, laundry, meal assistance, safety checks seven (7) times per day, and recording the following three (3) times per day: bowel movement (BM), meal percentage, and pain. R1 nursing assessment dated May 18, 2026, indicated R1 was independent with bathing, dressing, escorts, hygiene/grooming/oral, mobility, toileting, transfers, and making financial, medical and legal decisions. The assessment also indicated R1's nutritional and hydration status was normal and R1 had normal mental functioning. Under R1's physical assessment, R1 denied active digestion problems, and reported no pain but did indicate R1 took gabapentin and Tylenol for pain. R1's Vital Signs-One Resident dated May 1, 2026, through June 2, 2026, included a number value of 0 (none), 1 (some), and 2 (great). Staff documented the following: -May 1, 2026, value of 2; -May 16, 2026, value of 1; and -remaining 92 entries were a value of 0, some included notes indicating no pain. R1's medication administration record (MAR) dated May and June 2026, indicated R1 did not receive as needed (PRN) Tylenol for pain. During observation on June 2, 2026, at 1:30 p.m., unlicensed personnel (ULP)-B administered gabapentin 100 milligram (mg), one capsule by mouth three times per day.	0 450		

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0 450	Continued From page 3 R2 R2 was admitted to the licensee on February 18, 2026, with diagnoses including hypertension, major depression with psychotic features, and schizoaffective disorder. R2's Service Plan signed February 18, 2026, indicated R2 received services which included medication administration, activity assistance, bathing reminder, behavior documentation, behavior management, grooming, housekeeping, laundry, meal assistance, safety checks daily, and recording the following three (3) times per day: BM, meal percentage, and pain. R2's nursing assessment dated March 5, 2026, indicated R2 was independent with bathing, dressing, eating, escorts, hygiene/grooming/oral, mobility, toileting, transfers, and making financial, medical and legal decisions. The assessment also indicated R2's nutritional and hydration status was normal. Under R2's physical assessment, R2 has a history of constipation and was receiving scheduled and PRN laxative. R2 reported no pain. R2's MAR dated May 2026, did not include scheduled laxative, but included senna 8.6 mg, one tablet by mouth daily PRN for constipation. Staff administered PRN senna 16 out of 31 days and included notes indicating it was "done" or "effective." During interview on June 2, 2026, at 11:00 a.m., R1 explained he received gabapentin for right shoulder pain and would take Tylenol if needed. He stated staff were good about providing him ice packs if needed and felt staff cared about him when they asked questions about his BM and pain.	0 450		

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0 450	Continued From page 4 On June 2, 2026, at 12:35 p.m., ULP-B showed the surveyor the scheduled tasks for BM, meal intake, and pain recording on the electronic health record program (Residex). For pain, they record a number between 0 and 2, for BM, they document resident's BM, and document percent of meal eaten. ULP-B stated they performed these tasks for everyone, and most of the time, residents say they have no pain. ULP-B stated R1 and R2 almost always ate 100% of their meals, R3 was trying to lose weight and R4 could not lose any more weight. ULP-B stated the residents did not give him a hard time asking these questions. During interview on June 3, 2026, at 11:22 a.m., clinical nurse supervisor (CNS)-A was asked if all residents received BM, pain, and meal intake recording three times per day, he stated "I think so." When asked why those services were being performed on everyone, CNS-A stated they were assisting with comfort, they had standing orders that included medications for pain and constipation to assist with comfort. For meal intake, CNS-A stated they track it because residents have complained about not getting enough food. CNS-A stated all residents had the ability to seek medication for pain or constipation if needed but some residents may not voice they need help. During the nursing assessments, CNS-A explained residents would inform him they did not have pain at the time of the assessment but the assessment lacked a pain assessment. During exit conference on June 3, 2026, at 3:45 p.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-D explained they had a resident that became impacted and as nurses they wanted to prevent that from occurring.	0 450		

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0 450	Continued From page 5 LALD/LPN-D also explained that residents with mental illness take medications that could make them constipated. The Minnesota Bill of Rights for Assisted Living dated January 1, 2026, indicated residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. The licensee's 6.08 Service Plan policy dated August 1, 2021, indicated all residents receiving assisted living services would have a service plan in place. Service plans are based on the outcomes of initial and subsequent assessments, reassessments, monitoring, and individual reviews of the resident's needs or preferences. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 450		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster	0 470		

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0 470	Continued From page 6 situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the clinical nurse supervisor (CNS) developed and implemented a staffing plan to determine staffing levels to meet the needs of all residents, which included reviewing the staffing plan at least twice per year. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: During the entrance conference on June 1, 2026,	0 470		

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0 470	Continued From page 7 at 10:15 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-D and clinical nurse supervisor (CNS)-A stated the licensee was familiar with the current minimum assisted living license requirements and had a current census of four (4) residents. In addition, they stated they had three shifts as follows: - morning shift (7:00 a.m. to 3:00 p.m.) 1 unlicensed personnel (ULP); - evening shift (3:00 p.m. to 11:00 p.m.) 1 ULP; - night shift (11:00 p.m. to 7:00 a.m.) 1 ULP; and - a second ULP scheduled 9:00 a.m. to 5:00 p.m. seven (7) days a week. On June 1, 2026, at 11:50 a.m., the surveyor observed the posted GCF Master Schedule for Falstaff House from May 24, 2026, through June 6, 2026, which included the employee names and total hours scheduled for the time period. However, the schedule was unclear for the following reasons: -On May 24, 2026, 2 ULPs overlapped from 3:00 p.m. to 9:00 p.m.; -On May 25-26, 2026, included 1 ULP for morning, evening, and night shift and 9-5 (9:00 a.m. to 5:00 p.m.) was left blank, -On May 27, 2026, and June 3, 2026, 2 ULP for morning shift, 1 ULP on evening and night shifts; -On May 28-29, 2026, morning shift was left blank (one name was redacted for the 28th), 1 ULP for evening and overnight shifts; -On June 2, 4, and 5, 2026, 1 ULP for morning and night shift, evening shifts were blank along with 9-5 shift; -On May 30, 31, 2026, and June 6, 2026, included 1 ULP from 7:00 a.m. to 9:00 p.m. (one name was redacted for two morning shift), then 1 ULP from 11:00 p.m. to 7:00 a.m., which was unknown if an ULP was available from 9:00 p.m. to 11:00p.m. (2 hours); and	0 470		

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0 470	Continued From page 8 -On June 1, 2026, 1 ULP for morning and overnight shifts, and 1 ULP for 9-5 shift but evening shift was left blank. The licensee's staffing plan reviewed by LALD/LPN-D and house manager (HM)-C on December 24, 2025, indicated the approach to determine needs for increased or reduced staff would be based on number of clients (residents) in the house, clients (residents) needs and unexpected change in condition or behavior. The plan indicated the following information: -number of clients (residents) if full-4; -number of staff if full: 2 per shift; -number of licensed staff: 2 available on phone 24/7 and onsite is variable; -number of leads/supervisors: 1; -number of awake staff: 1-2 depending on the need and number of clients (residents). During observations on June 1-2, 2026, the surveyor observed ULP-B and ULP-E both working during the day on both days completing various tasks. On June 1, 2026, at 2:30 p.m., the surveyor asked what shift ULP-E was working, ULP-E stated he was working the "7-3 shift like [name of ULP-B]," and that the "9-5 shift was hard for people because they work other jobs." On June 1, 2026, at 3:10 p.m., the surveyor observed ULP-H arrive to the facility to work the evening shift (the evening shift on the staff schedule was blank). During interview on June 3, 2026, at 10:23 a.m., the surveyor asked LALD/LPN-D who created and reviewed the staffing plan, where LALD/LPN-D responded that she did. Her explanation for the blanks on the schedule was	0 470		

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0 470	Continued From page 9 because they had three people out on vacation or for another reason and the 2nd person working 7-3 was temporary but had hired a new person to fill the 9-5 shift. During interview on June 3, 2026, at 11:22 a.m., CNS-A stated he did review the staffing plan in collaboration with LALD/LPN-D. The 24-hour daily staff schedule was not complete for the days the surveyor was at the facility and the staffing plan defaulted to the number of staff per shift if the facility was at full capacity and gave a range of number of staff for awake staffs depending on the need and number of residents (did not specify what the actual needs were for the awake shift). The licensee's 4.06 Staffing and Scheduling policy dated August 1, 2021, indicated the licensee would assure qualified employees would be scheduled to meet operational requirements and the needs of the residents. The CNS must ensure that staffing levels were adequate to address resident needs based on resident's service plan, acuity level, and staff's ability to timely meet the resident's scheduled and reasonably foreseeable unscheduled needs. The CNS would develop a 24-hour daily staffing schedule that would identify the direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked, and the direct-care staff member's resident assignments or work location. Minnesota Administrative Rule 4659.0180, Subpart 3 dated August 11, 2021, indicated the clinical nurse supervisor must develop and implement a written staffing plan that provided an adequate number of qualified direct-care staff to	0 470		

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0 470	Continued From page 10 meet the residents' needs 24 hours a day, seven days a week. When developing a direct-care staffing plan, the clinical nurse supervisor must ensure that staffing levels were adequate to address the following: a. each resident's needs, as identified in the resident's service plan and assisted living contract; b. each resident's acuity level, as determined by the most recent assessment or individualized review; c. the ability of staff to timely meet the residents' scheduled and reasonably foreseeable unscheduled needs given the physical layout of the facility premises; d. whether the facility has a secured dementia care unit; and e. staff experience, training, and competency. No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently	0 480		

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0 480	Continued From page 11 enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door.	0 480		

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0 480	Continued From page 12 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated June 2, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced	0 775		

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0 775	Continued From page 13 by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated June 3 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		
0 800 SS=C	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.	0 800		

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0 800	Continued From page 14 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated June 3 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	0 800		
01290 SS=D	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring	01290		

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01290	Continued From page 15 self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license for two (2) of 13 employees (unlicensed personnel (ULP)-E, ULP-F). This had the potential to affect all residents living in the facility. 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 1, 2026, 11:10 a.m., the surveyor requested the NETStudy Roster 2.0 from licensed assisted living director/licensed practical nurse (LALD/LPN)-D. On June 1, 2026, at 1:40 p.m., LALD/LPN-D explained she was unable to log into the system	01290		

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01290	Continued From page 16 to obtain the NETStudy Roster, so the surveyor requested the roster from their supervisor. The licensee's roster dated June 1, 2026, did not list ULP-E and ULP-F being affiliated to HFID 35718. ULP-E ULP-E was hired November 11, 2023, to provide direct care services for the licensee's residents. During observations conducted on June 1-2, 2026, between 8:30 a.m. and 3:00 p.m., the surveyor noted that ULP-E took multiple residents on outings, engaged in one on one interactions with residents, and provided ongoing supervision. ULP-E's Person Summary dated June 1, 2026, provided by surveyor's supervisor, indicated ULP-E was affiliated to four (4) sister facilities owned by licensee. ULP-F ULP-F was hired on August 31, 2022, to provide direct care services for the licensee's residents. ULP-F's Person Summary dated June 1, 2026, provided by surveyor's supervisor, indicated ULP-F was affiliated to licensee's closed comprehensive license HFID 33800 which should have been closed by Minnesota Department of Human Services. During interview on June 3, 2026, at 10:23 a.m., LALD/LPN-D stated all staff needed to be affiliated to each facility they worked at, so her process was to affiliate all staff to all locations, but she must have missed ULP-E and ULP-F. LALD/LPN-D was able to log into the NETStudy 2.0 program and verbalized ULP-E was not on	01290		

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01290	Continued From page 17 the roster and said "I honestly thought I did everyone." The licensee's 4.02 Background Studies policy dated August 1, 2021, indicated the licensee would conduct a Minnesota Department of Human Services Background Study on all employees, volunteers, and contractors. No employee may provide direct services and have independent direct contact with any residents until acceptable result of the background study had been received. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery.	01620		

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01620	Continued From page 18 (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed comprehensive assessments to include all required content identified per Minnesota Administrative Rule 4659.0150 Uniform Assessment Tool for one of two residents (R1).	01620		

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01620	Continued From page 19 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: R1 was admitted to the licensee on April 24, 2023, with diagnoses including type 2 diabetes mellitus, schizoaffective disorder, antisocial personality disorder, and depression. R1's Service Plan signed November 27, 2025, indicated R1 received services which included medication administration, activity assistance, bathing reminder, behavior documentation, behavior management, grooming, housekeeping, laundry, meal assistance, safety checks seven (7) times per day, and recording the following three (3) times per day: bowel movement (BM), meal percentage, and pain. R1 nursing assessments dated February 13, 2026, and May 18, 2026, indicated R1 reported no pain but did indicate R1 took gabapentin and Tylenol for pain. Under musculoskeletal issue, it included R1 had occasional shoulder/upper arm pain related to past accident. R1's nursing assessments failed to address R1's pain intensity, duration, and effectiveness of medication and nonmedication alternatives. During interview on June 2, 2026, at 11:00 a.m., R1 stated he took gabapentin for his right	01620		

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01620	Continued From page 20 shoulder pain and took Tylenol or used ice packs if needed. He stated he was scheduled to have surgery on the shoulder February 2027. During phone interview on June 3, 2026, at 11:22 a.m., clinical nurse supervisor (CNS)-A explained the nursing assessment documented "no reported pain" because at the time of the assessment, R1 did not have any pain. CNS-A stated the assessment lacked a pain assessment to include intensity, duration, effective of medication and non-medication alternatives. The licensee's 6.03 Uniform Assessment Tool policy dated August 1, 2021, indicated the uniform assessment tool would include an assessment of pain including: location, frequency, intensity, and duration, and effectiveness of medications and non-medication alternatives. Minnesota Administrative Rule 4659.0150, subpart 1 dated August 11, 2021, indicated the required elements of the uniform assessment tool to comprehensively evaluate a resident's physical, mental, and cognitive needs. The assessment of pain included location, frequency, intensity, and duration; and the effectiveness of medication and non-medication alternatives. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse,	01730		

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01730	Continued From page 21 advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing	01730		

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01730	Continued From page 22 medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized medication management plan with the required content for one of two residents (R1) receiving medication management services. 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: R1 was admitted to the licensee on April 24, 2023, with diagnoses including type 2 diabetes mellitus, schizoaffective disorder, antisocial personality disorder, and depression. R1's Service Plan signed November 27, 2025, indicated R1 received services which included medication administration four times daily and once weekly. During observation on June 2, 2026, at 9:10 a.m., the surveyor noted a locked dorm sized black refrigerator in the dining room area and asked to see its contents. Unlicensed personnel (ULP)-B unlocked the refrigerator, and the surveyor noted a box containing three (3) of R1's Mounjaro injection pens, used to regulate blood sugar and	01730		

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01730	Continued From page 23 reduce food intake. R1 Individualized Medication Management Plan (IMMP) completed on May 18, 2026, lacked the following required content: - a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with manufacturer's instructions (related to refrigerated medications); and -identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis. During phone interview on June 3, 2026, at 11:22 a.m., clinical nurse supervisor (CNS)-A stated the registered nurse was responsible for monitoring medication supplies and reordering in conjunction with the staff. CNS-A stated he could not locate the required information on R1's IMMP. The licensee's 7.03 Medication Management Individualized Plan policy dated August 1, 2021, indicated the licensee would develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the above missing content. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the	01760		

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01760	Continued From page 24 resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prescriber's orders were accurately transcribed for one of two residents (R1) receiving medication services. 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: R1 was admitted to the licensee on April 24, 2023, with diagnoses including type 2 diabetes mellitus, gastroesophageal reflux disease (GERD), schizoaffective disorder, antisocial personality disorder, and depression. R1's Service Plan signed November 27, 2025, indicated R1 received services which included	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35718	A. BUILDING: _____ B. WING _____	06/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREATERCARE FACILITIES LLC	6576 FALSTAFF TERRACE WOODBURY, MN 55125

(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
01760	Continued From page 25 medication administration four times daily and once weekly. During observation on June 2, 2026, at 1:30 p.m., unlicensed personnel (ULP)-B administered gabapentin 100 milligrams (mg), one capsule by mouth three times per day. On June 1, 2026, at 4:00 p.m., via email, the licensee provided R1's medication list dated November 20, 2025, indicating to give omeprazole 20 mg, one capsule by mouth once daily to treat excess stomach acid. On June 2, 2026, at 2:34 p.m., via email, the licensee provided R1's electronically signed orders faxed by the pharmacy. During medication reconciliation, the surveyor noted the omeprazole order dated April 27, 2026, instructed to give one capsule twice daily, one hour before a meal. R1's medication administration record (MAR) dated May 1, through June 2, 2026, indicated staff administered one capsule of omeprazole 20 mg daily. On June 2, 2026, at 2:45 p.m., the medication cart contained two bubble packs of omeprazole 20 mg, one capsule by mouth two times a day for 8:00 p.m., dispensed on April 27, 2026 (15 capsules) and another card dispensed on May 9, 2026, (28 capsules). The surveyor asked unlicensed personnel (ULP)-B to check the MAR and see if it instructed to give once or twice a day. The MAR showed once a day and ULP-B stated he was not aware those were in the medication cart. During interview on June 2, 2026, at 3:35 p.m., R1 stated he had symptoms of GERD, he stated	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35718	A. BUILDING: _____ B. WING _____	06/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREATERCARE FACILITIES LLC	6576 FALSTAFF TERRACE WOODBURY, MN 55125

(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
01760	Continued From page 26 his doctor had increased the frequency to twice daily but he had not been receiving the second dose. During phone interview on June 2, 2026, at 3:10 p.m., clinical nurse supervisor (CNS)-A stated he was not aware there was an order increasing the omeprazole from once daily to twice daily. He stated he had access to R1's orders on "Omniview" and said he located the new order. CNS-A explained the change must have been made without his knowledge and that R1 sometimes contacted his provider without him knowing. He said he was working on collaborating with R1. CNS-A also stated "Omniview" was a work in progress. The licensee failed to ensure R1's MAR instructions for omeprazole were transcribed to match the signed prescriber's order increasing the frequency. The licensee's 7.16 Medication and Treatment Orders-Implementing policy dated August 1, 2021, indicated upon receipt of a medication and/or treatment order, whether new or change of an order from an authorized prescriber, a licensed nurse must take action to implement the order within 24 hours. The licensee's 7.19 Medication and Supplies-Reordering policy dated August 1, 2021, indicated a nurse would reconcile the medications when they arrive from the pharmacy. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		

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

GREATERCARE FACILITIES LLC
6576 FALSTAFF TERRACE
Woodbury, MN 55125
Washington County
Parcel:

Phone:
admin@greatercarefacilities.com

License Info

License: HFID 35718

Risk:
License:
Expires on:
CFPM: Ijeoma Onyejeke
CFPM #: 61522; Exp: 8/11/2028

Inspection Info

Report Number: F1031261186
Inspection Type: Full - Single
Date: 6/2/2026 Time: 11am
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 1
Delivery: Emailed

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control
6-501.12A *Priority Level: Priority 3 CFP#: 55*
MN Rule 4626.1520A Clean and maintain all physical facilities clean.
COMMENT:
KITCHEN CEILING HAS DEPOSITS OF DUST HANGING FROM TEXTURE.
REMOVE ALL COUNTER ITEMS AND CLEAN CEILING.
KITCHEN SURFACES MUST BE CLEANED AND SANITIZED AFTERWARDS.

Comply By: 6/23/2026 *Originally Issued On: 6/2/2026*

Food & Beverage General Comment

Nurse Evaluator on site: Anna B

All violations discussed with PIC during the inspection.

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

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

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

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Metro District Office inspection report number F1031261186 from 6/2/2026

Ijeoma Onyejeke
Person in Charge

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

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

Temperature Observations/Recordings

Establishment Info

GREATERCARE FACILITIES LLC
Woodbury
County/Group: Washington County

Inspection Info

Report Number: F1031261186
Inspection Type: Full
Date: 6/2/2026
Time: 11am

Food Temperature: Product/Item/Unit: Milk**; Temperature Process:** Cold-Holding
Location: Refrigerator (kitchen) at 38 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: Ambient**; Temperature Process:** Ambient Air
Location: Refrigerator (downstairs) at 33.5 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

GREATERCARE FACILITIES LLC
Woodbury
County/Group: Washington County

Inspection Info

Report Number: F1031261186
Inspection Type: Full
Date: 6/2/2026
Time: 11am

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Kitchen **Equal To** 160 Degrees F.
Comment:
Violation Issued?: No

Sanitizing Chemical: **Product:** Chlorine**; Sanitizing Process:** Wiping Cloth Bucket
Location: Kitchen **Equal To** 200 PPM
Comment:
Violation Issued?: No

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL35718016-0	**Date:** 6/3/2026
Facility Name: Greatercare Facilities LLC	
Facility Address: 6576 Falstaff Terrace Woodbury, MN 55125	

☒ **TAG IDENTIFICATION: 0775**

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

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]

2. Lighted matches, cigarettes, cigars or other burning object shall not be discarded in such a manner that could cause ignition of other combustible material. [Minn. Stat. 144G.45 subd. 2; MSFC 310.7]

   Comments: At the time of survey, in the garage, the Southeast and East Yards had discarded cigarette butts in the grass. There were multiple approved disposal containers available for disposal.

3. Open junction boxes and open-wiring splices shall be prohibited. Approved covers shall be provided for all switch and electrical outlet boxes. [Minn. Stat. 144G.45 subd. 2; MSFC 604.6]

   Comments: In the lower-level common room on the Southeast wall there was a damaged outlet cover. The chandelier in the office area has exposed wire splices not in a junction box.

4. In buildings that contain a fuel-burning appliance or fireplace, or attached private garage, carbon monoxide detection shall be installed in dwelling units within ten feet of bedrooms. Where a fuel burning appliance is located in a bedroom or its attached bathroom, carbon monoxide detection shall be installed within the bedroom. Carbon monoxide detection can be provided by carbon monoxide alarms installed in dwelling or sleeping units or a carbon monoxide detection system installed in the room or space that contains the fuel-burning appliance. [Minn. Stat. 144G.45 subd. 2; MSFC 915]

   Comments: On the mail level there was not a carbon monoxide alarm within ten feet of the resident sleeping rooms. The closest carbon monoxide alarm was in the main level common room.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 1; Widespread **TIME PERIOD OF CORRECTION:** Twenty One (21) days

1. The physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment are in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. [Minn. Stat. 144G.45 subd.2]

   Comments: The main level deck screen door was damaged and not installed, being stored on the deck.

   The lower-level bathroom had two holes in wall on the right as entering.

   In the dining room and resident room 1 there was a large amount of nasal mucus smeared on the walls.