Electronically Delivered

April 29, 2026

Licensee
Oak Terrace Housing of Jordan
622 Aberdeen Avenue
Jordan, MN 55352

RE: Project Number(s) SL28513016

Dear Licensee:

On April 17, 2026, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on April 17, 2026. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

KKM

Electronically Delivered

February 27, 2026

Licensee
Oak Terrace Housing of Jordan
622 Aberdeen Avenue
Jordan, MN 55352

RE: Project Number(s) SL28513016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 12, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

Level 1: no fines or enforcement;
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00
St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $1,000.00

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

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

The correction order documentation should include the following:

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

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

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

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

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

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

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

KKM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28513	A. BUILDING: _____ B. WING _____	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK TERRACE HOUSING OF JORDAN	622 ABERDEEN AVENUE JORDAN, MN 55352

(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: SL28513016-0 On February 9, 2026, through February 12, 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 68 residents; 66 receiving services under the Assisted Living Facility with Dementia Care license. 1290: An immediate correction order was issued on February 10, 2026, at a level 3/Widespread. The licensee took immediate action; however, the scope and level remains at I.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated February 9, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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0 480	Continued From page 3 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated February 11, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		

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0 900	Continued From page 4	0 900		
0 900 SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract prior to providing assisted living services for one of four residents (R2).	0 900		

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0 900	Continued From page 5 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted on May 6, 2025, with diagnoses including Parkinson's disease, anxiety, and depression. R2's Service Plan effective January 1, 2026, indicated R2 received services including medication administration, assistance with dressing, AFO (ankle-foot orthosis) brace, bathing, toileting, light housekeeping, and laundry. R2's Assisted Living Contract indicated a contract start date of May 6, 2025. The contract was signed by R2's legal representative on May 7, 2025, one day after the licensee provided services to R2. On February 11, 2026, at 10:07 a.m., licensed assisted living director (LALD)-A stated R2 had admitted late in the day on May 6, 2025, and LALD-A needed to go home prior to R2's arrival; therefore R2's contract was not signed by the legal representative until the following day. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One	0 900		

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0 900	Continued From page 6 (21) days	0 900		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was current and eligible on NETStudy 2.0 (web-based system for submitting background study requests to the Department of Human Services (DHS)) with the assisted living license for seven of 86 employees (unlicensed personnel (ULP)-H, ULP-K, ULP-L, dietary director (DD)-I, dietary aide (DA)-J, licensed practical nurse (LPN)-F, registered nurse (RN)-G). This had the potential to affect all residents residing in the facility. This resulted in an immediate correction order issued on February 10, 2026. This practice resulted in a level three violation (a	01290		

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01290	Continued From page 7 violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-H ULP-H was hired on October 17, 2016, to provide direct care services for the licensee's residents. ULP-K ULP-K was hired on October 20, 2022, to provide direct care services for the licensee's residents. ULP-L ULP-L was hired on February 16, 2022, to provide direct care services for the licensee's residents. DD-I DD-I was hired on March 28, 2022, to provide dietary services for the licensee's residents. DA-J DA-J was hired on November 1, 2023, to assist with dietary services for the licensee's residents. LPN-F LPN-F was hired on July 25, 2024, to provide direct care nursing services for the licensee's residents. LPN-F's nursing license was issued on October 4, 1994. RN-G RN-G was hired on January 21, 2026, to provide nursing services for the licensee's residents.	01290		

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01290	Continued From page 8 RN-G's nursing license was issued on June 13, 2008. On February 9, 2026, at 1:38 p.m., licensed assisted living director (LALD)-A provided the surveyor with the licensee's NETStudy employee roster; ULP-H, ULP-K, ULP-L, DD-I, DA-J, LPN-F, and RN-G were not included on the roster. Review of ULP-H, ULP-K, ULP-L, DD-I, DA-J, LPN-F, and RN-J's current status in NETStudy under the licensee's health facility identification number (HFID) 28513, indicated the following: ULP-H - separated from employment August 5, 2022; ULP-K - separated from employment November 5, 2022; ULP-L - separated from employment August 30, 2023; DD-I - separated from employment April 14, 2022; DA-J - separated from employment November 1, 2023; and LPN-F and RN-J were not identified as ever having worked for the licensee in NETStudy. On February 10, 2026, at 11:00 a.m., LALD-A stated ULP-H, ULP-K, and ULP-L were still employed on a casual basis. DD-I, DA-J, LPN-F, and RN-G were also still employed at the facility. LALD-A stated the ULPs and dietary staff had continued their employment since their original hire and wasn't sure why NETStudy would show them as separated. As for LPN-F and RN-G, LALD-A stated since they were licensed nurses she did not think she had to include them in the NETStudy employee roster. LALD-A further stated being unaware if a nurse was licensed prior to 2018, they would need to be included.	01290		

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01290	Continued From page 9 LALD-A also stated all of the above employees worked independently without supervision. The licensee's 4.02 Background Studies policy dated August 1, 2021, indicated: 1. Using the MN DHS NETStudy online program, [licensee name] will initiate a background study on all employees being considered for hire. 2. If hired prior to receiving the results of the background study, or the tentative background study results indicate more time is needed requiring supervision, new hires shall not be permitted to interact or provide services to tenants or clients (residents) of [licensee name] except under the direct supervision (eyesight) of another qualified staff person. 3. Once an approved background study has been received, staff may act independently with residents, assuming all other requirements have been met. 4. Copies of completed background studies shall be kept in individual employee records. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate On February 10, 2026, the facility implemented corrective actions to address this issue. The scope and severity remains at I.	01290		
01610 SS=F	144G.70 Subd. 2 (a-b) 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	01610		

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01610	Continued From page 10 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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted an initial assessment for one of one new resident (R2) prior to initiation of 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 was admitted and started receiving services on May 6, 2025, with diagnoses including Parkinson's disease, anxiety, and depression. R2's Initial Assessment was dated May 6, 2025, though was not completed and signed by the	01610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28513	A. BUILDING: _____ B. WING _____	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK TERRACE HOUSING OF JORDAN	622 ABERDEEN AVENUE JORDAN, MN 55352

(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
01610	Continued From page 11 registered nurse (RN) until May 8, 2025 (two days after start of services). On February 11, 2026, at 9:51 a.m., clinical nurse supervisor (CNS)-B reviewed R2's initial (admission) assessment and stated she thought they had five days to complete it. CNS-B further stated an RN completes a pre-assessment for each resident prior to the resident's admission to the licensee. At 10:21 a.m., CNS-B produced R2's handwritten pre-admission assessment; the assessment was incomplete and did not include all required components of the uniform assessment tool. In addition, the pre-admission assessment had not been dated by the RN who completed it. The licensee's 6.01 Assessments, Reviews & Monitoring policy dated August 1, 2021, indicated the facility will 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. 1. The initial nursing assessment or reassessment must include all the elements of the uniform assessment tool as required, conducted in person, be in writing, dated, and signed by the registered nurse who conducted the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01610		

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01620	Continued From page 12	01620		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be	01620		

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01620	Continued From page 13 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 interview and record review, the licensee failed to ensure the registered nurse (RN) completed an assessment within 90 days from the previous assessment for two of four residents (R1, R3), and failed to complete a change in condition assessment when required for two of four residents (R2, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1's diagnoses included type II diabetes mellitus, chronic kidney disease, chronic obstructive pulmonary disease (COPD), major depressive	01620		

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01620	Continued From page 14 disorder, and obstructive sleep apnea. R1's Service Plan effective April 11, 2025, indicated R1 received services including medication administration, diabetes management, assistance with bathing, housekeeping, and laundry. R1's last three assessments were requested. Assessments completed July 8, 2025, October 17, 2025, and December 10, 2025, were provided. 101 days had passed between the July and October assessments, thus exceeding 90 calendar days. On February 11, 2026, at 9:51 a.m., clinical nurse supervisor (CNS)-B reviewed R1's assessments and stated the October 2025, assessment was completed late. R3 R3's diagnoses included amnesia, congestive heart failure, atrial fibrillation, type II diabetes mellitus with other diabetic kidney complication and foot ulcer. R3's Service Plan effective January 1, 2026, indicated R3 received services including medication administration, diabetes management, assistance with dressing, grooming, toileting, transfers, wound care, prosthetic, housekeeping, and laundry. R3's last three assessments were requested. Assessments completed July 16, 2025, October 16, 2025, and January 9, 2026, were provided. 92 days had passed between the July and October assessments, thus exceeding 90 calendar days.	01620		

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01620	Continued From page 15 On February 12, 2026, at 9:34 a.m., CNS-B reviewed R3's assessments and stated the October 2025, assessment was completed late. R2 R2's diagnoses included Parkinson's disease, depression, anxiety, and history of falling. R2's Service Plan effective January 1, 2026, indicated R2 received services including medication administration, assistance with dressing, AFO (ankle-foot orthosis) brace, bathing, toileting, light housekeeping, and laundry. R2's progress note dated October 19, 2025, at 9:29 a.m., indicated R2 had been sent to the hospital for symptoms of a urinary tract infection (UTI) and was subsequently admitted to the hospital. R2's progress note dated October 27, 2025, at 14:12 (2:12 p.m.) indicated R2 had been sent from the hospital to a skilled nursing facility transitional care unit (TCU). R2's progress note dated October 31, 2025, at 10:38 a.m. indicated RN-O had visited R2 at the TCU to assess R2's ability to return to the licensee. The following note dated November 4, 2025, at 12:45 p.m., indicated R2 returned to the licensee. R2's assessment upon return from hospitalization/TCU was dated November 7, 2025; three days after R2's return to the licensee. In addition, R2's progress note dated January 15, 2026, at 10:18 a.m., indicated R2 requested to go to the hospital due to feeling more weak and	01620		

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01620	Continued From page 16 depressed. R2's progress notes further indicated R2 returned to the licensee on January 19, 2026, around 12:00 p.m. R2's assessment upon return from hospitalization was completed on January 21, 2026; two days after return to the licensee. On February 11, 2026, at 9:51 a.m., CNS-B stated when a resident returned from hospitalization, she would expect the RN to complete the assessment the day of return unless it was on the weekend. If a resident returned on the weekend, the RN would complete the assessment on Monday. R4 R4's diagnoses included Alzheimer's disease, major depressive disorder, anxiety, acute kidney failure, and history of falling. R4's Service Plan modified February 3, 2026, indicated R4 received services including medication administration, assistance with dressing, bathing, toileting, catheter care, housekeeping and laundry. R4's progress notes indicated R4 was hospitalized on December 31, 2025, after a fall and was diagnosed with a subdural (brain) bleed and a UTI. R4 returned to the licensee on January 6, 2026. R4's progress notes further indicated R4 was admitted to hospice on January 13, 2026. R4's assessment following hospitalization and admission to hospice was completed January 19, 2026; 13 days after hospitalization and six days after admission to hospice. On February 12, 2026, at 9:34 a.m., CNS-B	01620		

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01620	Continued From page 17 reviewed R4's record and could not find evidence a timely change of condition assessment had been completed by an RN following hospitalization and admission to hospice. CNS-B further stated understanding that an assessment following return from hospitalization needs to be completed the day of return to the licensee. The licensee's 6.01 Assessments, Reviews & Monitoring policy dated August 1, 2021, indicated: 3. Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. 6. The facility will conduct a nursing assessment during a holiday, and the weekend for a resident who is ready to be discharged from the hospital and return to the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the	01790		

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01790	Continued From page 18 medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative;	01790		

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01790	Continued From page 19 (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) developed training and competencies for unlicensed personnel (ULP) providing medications to residents for unplanned time away from home when the licensed nurse was not available for one of one unlicensed personnel (ULP-M). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-M was hired on April 30, 2021, to provide direct care services including medication administration to the licensee's residents. ULP-M's employee record lacked documentation of training and competencies for unplanned time away when the RN is not available.	01790		

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01790	Continued From page 20 On February 12, 2026, at 11:54 a.m., licensed assisted living director (LALD)-A stated ULP medication passers were trained on setting up medications for residents for unplanned time away when a nurse was not available. LALD-A was unsure if a training/competency was completed by the RN for this task. LALD-A checked with clinical nurse supervisor (CNS)-B who stated when new hires shadow the ULPs providing medication administration, the ULP trains the new hire on how to set-up and document medications for unplanned time away. CNS-B further stated an RN does not do competency testing for this delegated task. The licensee's 7.10 Medication Management - Planned & Unplanned Time Away policy dated August 1, 2021, indicated: For unplanned resident time away when a pharmacist or licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: 1. The registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date	02310		

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02310	Continued From page 21 service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards related to oxygen storage. 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 February 11, 2026, at 2:30 p.m., the surveyor observed one unsecured oxygen tank on the floor inside R6's apartment near the living room area. There was also a cardboard storage container that was separated into four slots, located next to the unsecured oxygen tank. Three of the fours slots contained an oxygen tank; the fourth slot was empty. The surveyor exited R6's apartment and alerted clinical nurse supervisor (CNS)-B of the unsecured oxygen tank. CNS-B stated the cardboard container in R6's apartment was what the oxygen company provided to store the delivered oxygen tanks. CNS-B further stated oxygen tanks should be secured and not loose on the floor. The licensee's 7.40 Oxygen policy dated August	02310		

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02310	Continued From page 22 1, 2021, indicated: 8. Oxygen cylinders and vessels must remain upright at all times. Never tip an oxygen cylinder or vessel on its side or try to roll it to a new location. Minnesota Department of Health's Oxygen Cylinder Storage Requirements document dated April 16, 2020, noted the cylinders must be secured with chains or racks. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

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

Oak Terrace Senior Housing
622 ABERDEEN AVENUE
Jordan, MN 55352
Scott County
Parcel:

Phone:

License Info

License: HFID 28513

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

Inspection Info

Report Number: F1062261025
Inspection Type: Full - Single
Date: 2/9/2026 Time: 10:30 am
Duration: minutes
Announced Inspection: Yes
Total Priority 1 Orders: 0
Total Priority 2 Orders: 1
Total Priority 3 Orders: 3
Delivery: Emailed

New Order: 2-100 Supervision
2-102.12AMN *Priority Level: Priority 3 CFP#: 2*
MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.
COMMENT: NO CFPM EMPLOYED AT FACILITY AT TIME OF INSPECTION. COMPLY WITH RULE.
Comply By: 2/9/2026 Originally Issued On: 2/9/2026

New Order: 3-300C Protection from Contamination: equipment/utensils, consumers
3-305.11A *Priority Level: Priority 3 CFP#: 39*
MN Rule 4626.0300A Store all food in a clean, dry location; where it is not exposed to splash, dust or other contamination; and at least 6 inches above the floor.
COMMENT: OBSERVED BOTTLES OF CHOCOLATE SAUCE AND A CAN OF VEGETABLES ON FLOOR OF DRY STORAGE. ENSURE FOOD PRODUCTS ARE STORED AT LEAST 6 INCHES ABOVE THE FLOOR.
Comply By: 2/9/2026 Originally Issued On: 2/9/2026

New Order: 4-600 Cleaning Equipment and Utensils
4-601.11C *Priority Level: Priority 3 CFP#: 49*
MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.
COMMENT: OBSERVED RESIDUE FROM JUICE BUILT UP AROUND DISPENSING NOZZLES OF JUICE DISPENSER IN KITCHEN. COMPLY WITH RULE.
Comply By: 2/9/2026 Originally Issued On: 2/9/2026

New Order: 6-300 Physical Facility Numbers and Capacities
6-301.12 *Priority Level: Priority 2 CFP#: 10*
MN Rule 4626.1445 Provide and maintain a supply of individual disposable towels, a continuous towel system, a heated-air hand drying device, or an approved ambient air temperature hand drying device at each handwashing sink or group of adjacent handwashing sinks.
COMMENT: HANDWASHING SINK BY OVEN/STOVE NOT SUPPLIED WITH PAPER TOWELS AT TIME OF INSPECTION. ENSURE HANDWASH SINKS ARE KEPT STOCKED WITH SOAP AND DISPOSABLE TOWELS DURING KITCHEN OPERATING HOURS.
Comply By: 2/9/2026 Originally Issued On: 2/9/2026

Food & Beverage General Comment

INSPECTION COMPLETED FOR WENDY BUCKHOLZ HRD.

COMMERCIAL KITCHEN

DISCUSSED CFPM REQUIREMENTS, COOK TEMPS AND PROHIBITED FOODS, AND SANITIZER REQUIREMENTS.

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 F1062261025 from 2/9/2026

ALEXANDRA FISHER
OPERATOR

Nicholas Streeter, RS
Public Health Sanitarian 2
nicholas.streeter@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

Oak Terrace Senior Housing
Jordan
County/Group: Scott County

Inspection Info

Report Number: F1062261025
Inspection Type: Full
Date: 2/9/2026
Time: 10:30 am

New Record: Product/Item/Unit: BOILED EGGS**; Temperature Process:** COOLING
Location: 2 DOOR COOLER at 47 Degrees F.
Comment: COOLING FROM AMBIENT LESS THAN 4 HOURS FROM INSPECTION
Violation Issued?: No

Food Temperature: Product/Item/Unit: LETTUCE**; Temperature Process:** Cold-Holding
Location: 2 DOOR COOLER at 41 Degrees F.
Comment: TEMP TAKEN FROM OUTSIDE OF PACKAGE
Violation Issued?: No

Food Temperature: Product/Item/Unit: MILK**; Temperature Process:** Cold-Holding
Location: 2 DOOR COOLER at 41 Degrees F.
Comment:
Violation Issued?: No

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

Sanitizer Observations/Recordings

Establishment Info

Oak Terrace Senior Housing
Jordan
County/Group: Scott County

Inspection Info

Report Number: F1062261025
Inspection Type: Full
Date: 2/9/2026
Time: 10:30 am

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Dishwashing Area **Equal To** 165 Degrees F.
Comment:
Violation Issued?: No

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** 3-Compartment Sink
Location: 3-Comp Sink **Equal To** 400 PPM
Comment:
Violation Issued?: No

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL28513016-0	**Date:** February 11, 2026
Facility Name: OAK TERRACE SENIOR HOUSING OF JORDAN	
Facility Address: 622 Aberdeen Ave, Jordan, MN 55352	

☒ **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. Fire doors shall be maintained to be self-closing and latch as designed. Fire doors shall not be blocked, obstructed, or otherwise made inoperable. [Minn. Stat. 144G.45 subd. 2; MSFC 705]

   Comments: Several resident room fire doors equipped with self-closing hinges no longer worked, preventing the door from closing and latching. Facility maintenance stated they will check all facility resident doors and add to monthly checklist going forward.

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

   Comments: Facility controlled egress system was not equipped with a separate de-activate button or switch in the fire command center or other approved location in place to unlock the system. Licensed assisted living director (LALD) stated they have bids for the project, and no other information was provided.