DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

February 20, 2026

Licensee
Greatercare Facilities LLC
2087 Woodbridge Way
Woodbury, MN 55125

RE: Project Number(s) SL37104016

Dear Licensee:

On February 18, 2026, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on December 11, 2025. 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,

Casey DeVries , Supervisor
State Evaluation Team
Email: Casey.DeVries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

KKM

Electronically Delivered

January 12, 2026

Licensee
Greatercare Facilities LLC
2087 Woodbridge Way
Woodbury, MN 55125

RE: Project Number(s) SL37104016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 11, 2025, 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:

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 $1,000.00**. 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,

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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37104	A. BUILDING: _____ B. WING _____	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREATERCARE FACILITIES LLC	2087 WOODBRIDGE WAY 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: SL37104016-0 On December 8, 2025, through December 11, 2025, 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; four receiving services under the Assisted Living Facility license. On December 10, 2025, an immediate correction order was issued for tag identification 1290. During the course of the survey, the licensee took action to mitigate the imminent risk. Noncompliance remained and the scope and level remain unchanged.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, 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 December 8, 2025, 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		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the required information about the licensee's grievance procedure and contact information for the regional Office of Ombudsman for Long-Term Care (OOLTC) and the Office of Ombudsman for Mental Health and Development Disabilities (OOMHDD). This had the potential to affect all of the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 550		

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0 550	Continued From page 4 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: On December 8, 2025, at 10:52 a.m., the surveyor observed an opening going into the kitchen off the front entry with the licensee's Complaint sample form taped to the wall providing contact name, phone number and email to submit the grievance to. The other side of the opening included a white plastic form holder that held few Complaint sample forms containing the same information. The posting lacked a grievance procedure and lacked contact information for OOLTC and OOMHDD. On December 8, 2025, at 3:27 p.m., the surveyor inquired about the required grievance procedure posting so licensed assisted living director (LALD)-D searched for the procedure but unable to locate it and stated the procedure was normally posted. The surveyor observed LALD-D post the grievance procedure with the missing content on the wall prior to survey completion. The licensee's 2.10 Complaint/Grievance Posting policy dated October 1, 2023, indicated the licensee would post, in a conspicuous place, information about their complaint/grievance procedure, and the name, telephone number, and email contact information for the individual(s) who were responsible for handling resident complaint/grievances. The policy also indicated the posting would include the contact information	0 550		

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0 550	Continued From page 5 for the OOLTC and OOMHDD. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 800 SS=E	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. 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 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).	0 800		

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0 800	Continued From page 6 The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated December 9, 2025, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Two (2) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at	0 810		

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0 810	Continued From page 7 least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated December 9, 2025, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty one (21) days	0 810		

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01060	Continued From page 8	01060		
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not	01060		

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01060	Continued From page 9 returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, or designated representative and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation greater than four days for one of one resident (R1). 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: Upon arrival to initiate survey on December 8, 2025, at 10:10 a.m., the surveyor was greeted by house manager (HM)-C. HM-C stated the current census was four (4) residents but one was currently at the hospital due to violet behavior that occurred while R1 was on his way to work and verbalized threats to injure others within the facility. R1 was admitted to the hospital on November 29, 2025. At 10:37 a.m., during facility tour with HM-C, the home was multi-level (4	01060		

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01060	Continued From page 10 levels total) where the main level had living room, kitchen, and dining room. The level going upstairs had three occupied bedrooms and bathroom. Going downstairs from the main level had a living room, bathroom, and one bedroom (R1's room with bed, miniature refrigerator, clothes, etc.). Another level off the lower level had a vacant room. R1 was admitted on February 10, 2022, to received assisted living services. R1's Resident Notes dated November 29, 2025, at 4:08 p.m., indicated R1 refused his ride to work with staff so he took an Uber ride to work, but got into a fight with the Uber driver. The police went to the facility to notify staff R1 was taken to the hospital. R1's record lacked evidence the licensee provided the resident or resident's representative a written emergency relocation notice. The record also lacked evidence to indicate the licensee provided the notification to the OOLTC of the emergency relocation greater than four days as required. On December 8, 2025, at 1:29 p.m., clinical nurse supervisor (CNS)-A notified R1's guardian R1 was sent to the hospital but did not send the required written emergency relocation notice. CNS-A thought OOLTC needed to be notified if the resident did not return within one week but then said three days. CNS-A stated OOLTC was not notified. The licensee's 1.23 Emergency Relocation policy dated October 1, 2023, indicated the license would provide the written notice containing the reason for the relocation, the name and contact	01060		

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	37104	A. BUILDING: _____ B. WING _____	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREATERCARE FACILITIES LLC	2087 WOODBRIDGE WAY 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
01060	Continued From page 11 information for the location to which the resident has been relocated and any new service provider, contact information for OOLTC and OOMHDD, approximate date or range of dates within which the resident is expected to return to the facility, and a statement that , if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal (including contact information for the agency to submit the appeal). The notice required would be delivered as soon as practicable to the resident/legal representative and OOLTC if resident has not returned to the facility within four days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
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.	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37104	A. BUILDING: _____ B. WING _____	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREATERCARE FACILITIES LLC	2087 WOODBRIDGE WAY 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
01290	Continued From page 12 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study (BGS) was submitted through Department of Human Services (DHS) NETStudy 2.0 and received in affiliation with the assisted living licensee's health facility identification number (HFID) for one of fifteen (15) employees (unlicensed personnel (ULP)-F). Additionally, the licensee failed to ensure a BGS remained cleared by obtaining required fingerprinting once emergency background studies expired for one of fifteen (15) employees (ULP)-E. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident), 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: During entrance conference on December 8, 2025, at 11:46 a.m., clinical nurse supervisor (CNS)-A stated two ULPs were scheduled on the morning (AM) shift (7:00 a.m. to 3:00 p.m.), two ULPs on the evening (PM) shift (3:00 p.m. to 11:00 p.m.), and one ULP on the overnight (NOC) shift (11:00 p.m. to 7:00 a.m.). The licensee's Staff List with as of date October 30, 2025, provided the following information: -ULP-F was hired on May 31, 2023; and -ULP-E was not listed as an employee for the facility.	01290	During the course of the survey, the licensee took action to mitigate the imminent risk. Noncompliance remained and the scope and level remain unchanged.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37104	A. BUILDING: _____ B. WING _____	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREATERCARE FACILITIES LLC	2087 WOODBRIDGE WAY 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
01290	Continued From page 13 The [licensee initials] Master Schedule for Woodbridge House dated November 16-29, 2025 (two-week schedule), indicated the following: -ULP-E was scheduled to work three shifts during that two-week period (AM shifts); -ULP-F was scheduled to work a total of five shifts during that two-week period (PM and NOC shifts). The [licensee initials] Master Schedule for Woodbridge House dated November 30, 2025, through December 13, 2025, indicated the same schedule as the one above. R2's Resident Notes indicated the following: -On December 7, 2025, at 7:34 a.m., ULP-F provided an end of shift note regarding R2. -On December 7, 2025, at 2:49 p.m., ULP-E provided an end of shift note regarding R2. At the end of the entrance conference on December 8, 2025, at 1:30 p.m., the surveyor requested the licensee's NETStudy 2.0 roster for HFID 37104. On December 9, 2025, at approximately 9:30 a.m., licensed assisted living director (LALD)-D provided the surveyor with a Person Summary document for ULP-B and ULP-J, but did not provide the requested NETStudy 2.0 roster. On December 9, 2025, at 10:14 a.m., the surveyor received the NETStudy 2.0 roster for HFID 37104 from the surveyor's supervisor and noted ULP-E was affiliated to HFID 37104 on July 19, 2021 (different date from Staff List) but ULP-E's COVID-19 BGS expired on December 31, 2022, and did not have fingerprints taken. The roster did not show ULP-F was affiliated to HFID 37104. The supervisor then obtained ULP-F's	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37104	A. BUILDING: _____ B. WING _____	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREATERCARE FACILITIES LLC	2087 WOODBRIDGE WAY 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
01290	Continued From page 14 Person Summary on NETStudy 2.0, which indicated ULP-F was "separated" from HFID 37104 on August 3, 2022, but indicated ULP-F was still affiliated to licensee's comprehensive license HFID 33800, but that BGS for ULP-F was a COVID-19 BGS that expired on December 31, 2022. ULP-E and ULP-F lacked a cleared BGS due to expired COVID-19 studies. On December 9, 2025, at 1:34 p.m., LALD-D stated she was responsible for completing BGS on all employees and it was her process to submit BGS prior to training and once cleared, staff were able to work with residents. LALD-D could not recall if she received any notification from DHS stating ULP-E and ULP-F's COVID-19 studies expired and required fingerprinting. The licensee's 4.02 Background Studies policy dated August 1, 2021, indicated no employee may have independent direct contact with any residents until acceptable result of the background study have been received. The Minnesota DHS Emergency background studies end website dated August 7, 2025, indicated emergency studies were no longer valid after December 31, 2022. The website stated that entities were responsible for identifying who needed to submit a new fully compliant, fingerprint-based background study. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate Additionally, the licensee failed to ensure a background study was affiliated to the current	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37104	A. BUILDING: _____ B. WING _____	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREATERCARE FACILITIES LLC	2087 WOODBRIDGE WAY WOODBURY, MN 55125

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01290	Continued From page 15 HFID number for six of ten employees (ULP-G, ULP-H, ULP-I, ULP-J, ULP-K, ULP-L) shown to have worked with the licensee's 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 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: The licensee's Staff List with as of date October 30, 2025, provided the following information: -ULP-I [different last name] was hired on August 19, 2025, to provide assisted living services; and -ULP-J was hired December 23, 2024, to provide assisted living services. ULP-G, ULP-H, ULP-K, and ULP-L were not listed as current employees. The [licensee initials] Master Schedule for Woodbridge House dated November 16-29, 2025 (two-week schedule), indicated the following: -ULP-H was scheduled to work one shift (PM); -ULP-I was scheduled to work two shifts (AM); and -ULP-K was scheduled to work four shifts (AM). The [licensee initials] Master Schedule for Woodbridge House dated November 30, 2025, through December 13, 2025, (two-week schedule), indicated the following: -ULP-G was scheduled to work two shifts (AM); -ULP-H was scheduled to work two shifts (AM); and	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37104	A. BUILDING: _____ B. WING _____	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREATERCARE FACILITIES LLC	2087 WOODBRIDGE WAY 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
01290	Continued From page 16 -ULP-I was scheduled to work one shift (AM). -ULP-L was scheduled to work one shift but ULP-L's name was crossed off. R2's November and December 2025 medication administration record (MAR) indicated ULP-G, ULP-H, ULP-K, and ULP-L initialed the MAR indicating they provided medication administration. At the end of the entrance conference on December 8, 2025, at 1:30 p.m., the surveyor requested the licensee's NETStudy 2.0 roster for HFID 37104. On December 9, 2025, at approximately 9:30 a.m., LALD-D provided the surveyor with a Person Summary document for ULP-J was affiliated to HFID 37104 on December 8, 2025, after the survey was initiated. On December 9, 2025, at 10:14 a.m., the surveyor received the NETStudy 2.0 roster for HFID 37104 from the surveyor's supervisor and the roster did not show ULP-G, ULP-H, ULP-K and ULP-L were affiliated to HFID 37104. The supervisor also provided Person Summary documents providing the following information: -ULP-G was affiliated to licensee's sister facility HFID 35864; -ULP-H was affiliated to licensee's comprehensive home care license HFID 33800 on October 11, 2019, which was no longer in effect as of August 1, 2021; -ULP-I was affiliated to licensee's sister facility HFID 35864 on December 2, 2024, then affiliated to HFID 37104 on December 9, 2025, after the survey was initiated; -ULP-K was affiliated to licensee's sister facility HFID 35864 on October 21, 2024; and	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37104	A. BUILDING: _____ B. WING _____	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01290	Continued From page 17 -ULP-L was affiliated to licensee's sister facility HFID 35718 on November 19, 2024. During interview on December 9, 2025, at 11:42 a.m., house manager (HM)-C stated they handled staff schedules and ULP-I worked two days every two-weeks and ULP-H worked every weekend on AM/PM shift and every other Friday. During interview on December 9, 2025, at 1:34 p.m., LALD-D stated upon hire, she affiliated staff to facilities they planned to work but going forward, she would affiliate staff to every facility. The licensee's 4.02 Background Studies policy dated August 1, 2021, did not provide information regarding BGS affiliation. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to discard expired medication for one of one resident (R2).	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37104	A. BUILDING: _____ B. WING _____	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREATERCARE FACILITIES LLC	2087 WOODBRIDGE WAY 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
01890	Continued From page 18 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During entrance conference on December 8, 2025, at 11:46 a.m., clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to all residents. Medications were stored within the facility's medication cart located in the kitchen. During medication cart review with house manager (HM)-C on December 8, 2025, at 2:30 p.m., in the top left drawer contained multiple tubes of creams, and ear drops. The following medications used for eczema (skin condition that causes dry and itchy patches of skin) were found for R2: -triamcinolone 0.1% cream (two tubes with same prescription number) with manufacturer expiration date of October 2025; and -tacrolimus 0.1% ointment (two full tubes) with manufacturer expiration date of September and October 2025. After medication cart review, HM-C explained R2 refused the cream/ointment, so it was not in use and staff were responsible for checking for expired medication. On December 9, 2025, at 9:56 a.m., CNS-A explained staff were trained to check expiration dates for scheduled medications, but CNS-A was	01890		

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	37104	A. BUILDING: _____ B. WING _____	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01890	Continued From page 19 responsible for checking as needed medications on a regular basis. CNS-A stated during his last check, he acknowledged there were expired medications but got distracted with resident behaviors and forgot to remove them. The licensee's 7.23 Medication Disposal policy dated October 1, 2023, indicated expired medications would be disposed of according to this policy. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

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
2087 Woodbridge Way
Woodbury, MN 55125
Washington County
Parcel:

Phone:

License Info

License: HFID 37104

Risk:
License:
Expires on:
CFPM: Peter Egbudom
CFPM #: 61779; Exp: 8/11/2028

Inspection Info

Report Number: F1031251208
Inspection Type: Full - Single
Date: 12/8/2025 Time: 10am
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 1
Total Priority 3 Orders: 5
Delivery: Emailed

New Order: 3-500C Microbial Control: date marking
3-501.17A *Priority Level: Priority 2 CFP#: 23*
MN Rule 4626.0400A Mark the refrigerated, ready-to-eat, TCS food prepared and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded.
COMMENT:
MULTIPLE ITEMS IN REFRIGERATOR ARE MISSING DATE MARKING.
FOLLOW ABOVE DIRECTION.
Comply By: 12/11/2025 Originally Issued On: 12/8/2025

New Order: 4-200 Equipment Design and Construction
4-204.11 *Priority Level: Priority 3 CFP#: 56*
MN Rule 4626.0565 Prevent grease or condensation from exhaust ventilation hood systems from draining or dripping onto food, equipment, utensils, linens, single-service articles, and single-use articles.
COMMENT:
STOVE HOOD FILTERS HAVE GREASE/DEBRIS BUILDUP.
CLEAN HOOD FILTERS.
Comply By: 12/29/2025 Originally Issued On: 12/8/2025

New Order: 4-600 Cleaning Equipment and Utensils
4-601.11B *Priority Level: Priority 3 CFP#: 49*
MN Rule 4626.0840B Maintain the food contact surfaces of cooking equipment and pans free of encrusted grease deposits and other soil accumulations.
COMMENT:
OVEN INTERIOR HAS SPILLS/SPLASHES.
CLEAN OVEN INTERIOR.
Comply By: 12/29/2025 Originally Issued On: 12/8/2025

New Order: 6-300 Physical Facility Numbers and Capacities
6-301.14 *Priority Level: Priority 3 CFP#: 10*
MN Rule 4626.1455 Remove the supply of individual disposable towels and hand soap from food preparation sinks, utensil washing sinks, and mop sinks.
COMMENT:
HANDWASH REMINDER SIGN MISSING FROM BOTH BATHROOMS.
COPY OF REMINDER SIGN SENT WITH REPORT. PRINT AND POST SIGN OR PURCHASE SIMILAR.
Comply By: 12/12/2025 Originally Issued On: 12/8/2025

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control
6-501.11 *Priority Level: Priority 3 CFP#: 55*
MN Rule 4626.1515 Maintain the physical facilities in good repair.
COMMENT:
1. MULTIPLE CUPBOARDS HAVE PAINT CHIPPED/PEELING.
REMOVE LOOSE PAINT AND REPAINT CUPBOARDS.

2. AREAS OF CUPBOARD INTERIORS HAVE EXPOSED WOOD.
PAINT OR EPOXY ALL EXPOSED WOOD IN CUPBOARDS.
Comply By: 12/29/2025 Originally Issued On: 12/8/2025

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:
CUPBOARDS AND COUNTERS HAVE SPLASHES/SPILLS ON SURFACES.
CLEAN AND KEEP CLEAN ALL CUPBOARD AND COUNTER SURAFCES.
Comply By: 12/29/2025 Originally Issued On: 12/8/2025

Food & Beverage General Comment

Nurse Evaluator on site: Anna Bohnen

All violations discussed with PIC during the inspection.

NOTES:

- 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.

- Staff must prepare sanitizer bucket or squirt bottle daily. Check concentration with test strips (50-200ppm Chlorine) when preparing solution.

- Establishment does not have pasteurized eggs and does not prepare eggs for consumption under 145F. Purchase pasteurized eggs if intending to serve eggs undercooked.

- Make sure to datemark any prepared cold items that are kept in refrigerator.

- Employee food needs to be labeled and separated from residents' food.

- Cutting boards should be utilized as food contact surfaces and not counters or plates.

- Establishment needs to check dish washer utensil temperature weekly (160F required). If utensil temp not reaching 160F, use washer to wash/rinse and sink basin with sanitizer solution to sanitize dishes then air dry, as discussed during inspection.

- 2-Comp sink has left basin designated for handwashing and the right basin for product washing/prep sink.

- When cooking/preparing food, make sure to use a thin-probe thermometer to check temperatures.

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 F1031251208 from 12/8/2025

Peter Egbudom
Manager

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: F1031251208
Inspection Type: Full
Date: 12/8/2025
Time: 10am

Food Temperature: Product/Item/Unit: Milk**; Temperature Process:** Cold-Holding
Location: Refrigerator (main) at 39 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Ambient**; Temperature Process:** Ambient Air
Location: Refrigerator (basement) at 40 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: F1031251208
Inspection Type: Full
Date: 12/8/2025
Time: 10am

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

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

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL37104016	**Date:** 12/9/2025
Facility Name: Greatcare Facilities LLC	
Facility Address: 2087 Woodbridge Way, Woodbury MN 55125	

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 2; Pattern **TIME PERIOD OF CORRECTION:** Two (2) 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 handle for the egress window in resident rooms 2 and 3 were not properly secured. The operating handles for the windows would only turn, but the windows could not be opened due to the handles not being properly secured.

☒ **TAG IDENTIFICATION: 0810**

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

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

   Comments: The fire safety and evacuation policy (FSEP) included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but the plan was designed for a building with life safety systems such as fire doors and smoke compartments. The policy had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility which did not have life safety systems or a fire-resistant construction type.

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

   Comments: The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. House manager (HM)-C stated that the policy does not contain any resident actions, and that it is a work in progress.

3. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. [Minn. Stat. 144G.45 subd.2]

   Comments: The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. HM-C stated that they had no written unique or unusual needs for residents during evacuation or similar emergency.

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

   Comments: HM-C provided training documentation indicating that staff were trained on the facilities FSEP one time in calendar year 2025. HM-C stated that staff also receive training in Educare on the Educare FSEP, and that staff receive training monthly when conducting fire drills, but lacked documentation that training was conducted monthly.