



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

February 24, 2026

Licensee

Eagancare Behavioral Health

1766 Gabbro Trail

Eagan, MN 55122

RE: Project Number(s) SL36221016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 11, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;

Level 3: a fine of \$1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

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

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

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

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

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

REQUESTING A HEARING

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

factor.

To submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEpHV>**. 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: 1-800-337-9238

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36221	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/11/2026
NAME OF PROVIDER OR SUPPLIER EAGANCARE BEHAVIORAL HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 1766 GABBRO TRAIL EAGAN, MN 55122		
(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: SL36221016-0 On February 9, 2026, through February 11, 2026, the Minnesota Department of Health conducted a change of ownership (CHOW) survey at the above provider. At the time of the survey, there were four residents; four receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or	0 700			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 700	Continued From page 1 electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure resident's personal health and medical information was kept private. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On February 9, 2026, at 11:00 a.m., the surveyor observed unlicensed personnel (ULP)-D lock the medication cart but left an opened laptop on the medication cart located in the open living room/common area of the facility while administering R1's medications. The computer screen displayed R1's name and medication information. On February 9, 2026, at 12:00 p.m., the surveyor observed ULP-D locking the medication cart after getting the medication, but left the laptop open	0 700			

Minnesota Department of Health

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0 700	Continued From page 2 and unsecured with R3's personal health information (PHI) visible on top of the medication cart in the living room/common area of the facility while administering R3's medications. On February 9, 2026, at 1:50 p.m., the surveyor observed ULP-D preparing R1's afternoon medication, locking the medication cart but left the laptop open and unsecured with R1's PHI visible on top of the medication cart in the living room/common area prior to leaving the room. On February 10, 2026, at 9:00 a.m., the surveyor observed the laptop on the medication cart left unsecured with resident PHI visible to all residents and staff in the living room/common area. On February 10, 2026, at 10:14 a.m., licensed assisted living director (LALD)-A stated he saw ULP-D leaving the laptop unsecured and stated the staff are trained to minimize the screen and secure it. The licensee's Privacy of Protected Health Information policy dated December 16, 2025, indicated staff will maintain confidentiality of protected health information in the office and when doing business on behalf of the licensee and no clinical records or personal health information about residents will be accessible in public areas of the office. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 700			
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment	0 775			

Minnesota Department of Health

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0 775	Continued From page 3 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			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds,	0 800			

Minnesota Department of Health

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0 800	Continued From page 4 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 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.	0 800			

Minnesota Department of Health

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01760	Continued From page 5	01760			
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to check a blood pressure with medication administration 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) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 started receiving services from the licensee on February 26, 2021, with a diagnosis of schizoaffective disorder, hypertension, and diabetes.	01760			

Minnesota Department of Health

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01760	Continued From page 6 R1's Service Plan dated December 2, 2025, indicated R1 received services including medication administration. R1's signed physician orders dated January 21, 2026, indicated R1 took diltiazem (used for high blood pressure) 60 milligrams (mg). The order reads: Take one tablet (60 mg) by mouth three times daily. You can take one additional tablet if the blood pressure (BP) stays more than 150/100 and does not come down with sitting and breathing for ten minutes. On February 10, 2026, at 1:50 p.m., the surveyor observed unlicensed personnel (ULP)-D administering diltiazem to R1 and returned to the medication cart to document administration of the medication. ULP-D failed to take blood pressure (BP) at the time of administration as ordered by the physician. Licensed assisted living director (LALD)-A stated the BP is not taken at every administration. On February 11, 2026, at 9:30 a.m., LALD-A corrected yesterday's statement, stating that R1's BP is done three times a day and not one time a day as previously stated. LALD-A stated ULP-D just forgot to do it. R1's record included a document for the month of January 2026, and February 2026, indicating BPs were taken and recorded multiple times a day. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			



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

Food & Beverage Inspection Report

Page: 1

Establishment Info

Eagancare Behavioral Health
1766 Gabbro Trail
Eagan, MN 55112
Dakota County
Parcel:

Phone:

License Info

License: HFID 36221

Risk:
License:
Expires on:
CFPM: JULIET KWAMBOKA
OMWERI
CFPM #: FM121977; Exp: 02/16/2027

Inspection Info

Report Number: F1005261040
Inspection Type: Full - Single
Date: 2/10/2026 Time: 10:15 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery:

No orders were issued for this inspection report.

Food & Beverage General Comment

INSPECTION COMPLETED WITH PERSON IN CHARGE AND REVIEWED WITH HRD NURSING EVALUATOR TRACEY FEARON.

FACILITY HAS AN IRREVERSIBLE REGISTERING THERMOMETER ON SITE WHICH WAS RUN THROUGH THE DISHWASHER PRIOR TO INSPECTION THIS MORNING, AND SHOWED A MAXIMUM TEMPERATURE OF 188 DEGREES F.

DISCUSSED DATE MARKING, GLOVE USE, COOKING TEMPERATURES, CROSS-CONTAMINATION, AND EMPLOYEE ILLNESS.

KITCHEN IS RESIDENTIAL AND FOOD IS PREPARED FOR SAME DAY SERVICE.

FLOORING IS LAMINATE, CABINETS ARE WOOD WITH HOLLOW BASE, COUNTERS ARE LAMINATE, AND CEILING HAS A POPCORN FINISH. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

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 F1005261040 from 2/10/2026

CALISTER BOGOMBA

Jessica Davis, REHS
Public Health Sanitarian 3
651-201-3961
jessica.davis@state.mn.us



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

Temperature Observations/Recordings

Page: 1

Establishment Info

Eagancare Behavioral Health
Eagan
County/Group: Dakota County

Inspection Info

Report Number: F1005261040
Inspection Type: Full
Date: 2/10/2026
Time: 10:15 AM

Food Temperature: **Product/Item/Unit:** MILK; **Temperature Process:** Cold-Holding

Location: KITCHEN REFRIGERATOR at 39 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** HAM; **Temperature Process:** Cold-Holding

Location: KITCHEN REFRIGERATOR 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

Page: 1

Establishment Info

Eagancare Behavioral Health
Eagan
County/Group: Dakota County

Inspection Info

Report Number: F1005261040
Inspection Type: Full
Date: 2/10/2026
Time: 10:15 AM

Sanitizing Equipment: Product: Hot Water; **Sanitizing Process:** DISHWASHER

Location: Equal To 188 Degrees F.

Comment:

Violation Issued?: No

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL36221016-0	Date: 2/11/2026
Facility Name: Eagancare Behavioral Health	
Facility Address: 1766 Gabbro Trail, Eagan, MN 55122	

☒ **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. In buildings that contain a fuel-burning appliance or fireplace, or attached private garage, carbon monoxide detection shall be installed in dwelling units within ten feet of bedrooms. [Minn. Stat. 144G.45 subd. 2; MSFC 915]

Comments: No carbon monoxide alarms were observed in the facility. LALD-A stated that the alarms outside the bedroom areas were combination smoke and carbon monoxide alarms. LALD-A removed the smoke alarm from the basement hall, and the alarm was labeled smoke alarm and did not indicate it was a carbon monoxide alarm.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Seven (7) 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 items below were observed during a facility tour on February 11, 2026, with LALD-A.

- *The electric baseboard heater in the basement was missing its cover. There was black tape on the wire where it entered the side of the heater and there was a black mark on the metal frame by the wire that appeared to be a burn mark.*
- *The railing around the rear deck and steps were loose in several areas.*
- *There were loose and slanted deck boards on several of the rear steps.*

- *The basement bathroom exhaust fan in the ceiling was drywalled over. Surveyor turned on the fan switch and heard fan running but could not see it. LALD-A stated they could feel vibration on the ceiling above the toilet area and thought that is where the fan was located. LALD-A was unsure why it had been covered up.*
- *There was a loose electric outlet and light switch in the kitchen.*
- *There were wall tiles missing from behind the toilet and under the shower door in the basement bathroom.*
- *There were holes in the wall by the sink and window in the basement bathroom.*
- *There were holes in the wall and the door in bedroom three. LALD-A stated the resident would hit the walls in the bedroom and bathroom.*