Electronically Delivered

July 1, 2026

Licensee
St Jude Home Health LLC
11261 West River Road
Champlin, MN 55316

RE: Project Number(s) SL41244015

Dear Licensee:

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

The Minnesota Department of Health completed an initial survey on June 3, 2026, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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

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:

0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - $500.00

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

The correction order documentation should include the following:

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

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

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

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 MDH 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:

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

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

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

If you have any questions, please contact me.

Sincerely,

Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 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
	41244	A. BUILDING: _____ B. WING _____	06/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JUDE HOME HEALTH LLC	11261 WEST RIVER ROAD CHAMPLIN, MN 55316

(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: SL41244015-0 On June 1, 2026, through June 3, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there was one resident who received services under the Provisional 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.	
0 480 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 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated June 1, 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		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for three of three residents (R1, R2, R3). In addition, the licensee failed to accurately assess R1's risk of abusing other vulnerable adults. 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).	0 630		

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0 630	Continued From page 4 The findings include: R1 R1 was admitted to the licensee on February 22, 2025, and began receiving assisted living services. R1's diagnoses included bipolar disorder (mental health condition characterized by significant mood swings, including manic episodes and depressive episodes), arthritis, chronic obstructive pulmonary disease (COPD), and diabetes. R1's Service Plan (Waiver) - Addendum to Contract signed February 24, 2025, indicated R1 received assistance with appointments, grooming, housekeeping, laundry, behavior management, meals, medication administration and set up, blood glucose monitoring, vital sign monitoring, safety check, and shopping. R1's ongoing assessment dated March 9, 2026, included R1's IAPP and indicated R1 was not at risk to abuse other vulnerable adults and was not at risk to abuse themselves. R1's IAPP lacked an individualized review or assessment of the resident's susceptibility to abuse by another individual. In addition, R1's assessment indicated R1 had previous episodes of physical aggression and read R1 "is a registered sex offender per police records." R1's IAPP did not accurately reflect R1's risk of abusing other vulnerable adults. R2 R2 was admitted to the licensee on December 23, 2025, and began receiving assisted living services. R2 discharged from the licensee on April 21, 2026.	0 630		

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0 630	Continued From page 5 R2's diagnoses included chronic heart failure (CHF). R2's Service Plan (Waiver)- Addendum to Contract signed December 26, 2025, indicated R2 received assistance with behavior management, medication administration, and vital sign monitoring. R2's ongoing assessment dated March 9, 2026, included R2's IAPP and indicated R2 was not at risk to abuse other vulnerable adults and was not at risk to abuse themselves. R2's IAPP lacked an individualized review or assessment of the resident's susceptibility to abuse by another individual. R3 R3 was admitted to the licensee on February 13, 2026, and began receiving assisted living services. R3 discharged from the licensee on April 20, 2026. R3's diagnoses included hypertension (HTN) and diabetes. R3's Service Plan (Waiver) - Addendum to Contract signed April 16, 2026, did not list services that would be provided to R3. R3's ongoing assessment dated March 9, 2026, included R3's IAPP and indicated R3 was not at risk to abuse other vulnerable adults and was not at risk to abuse themselves. R3's IAPP lacked an individualized review or assessment of the resident's susceptibility to abuse by another individual. On June 3, 2026, at 9:01 a.m., licensed assisted living director/clinical nurse supervisor	0 630		

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0 630	Continued From page 6 (LALD/CNS)-C stated the IAPP was created with the admission assessment and updated if there was a change of condition with the resident. LALD/CNS-C stated the IAPP assessment template located in Residex (a documenting software) contained if the resident was at risk to be abused and if the resident was at risk to abuse others. LALD/CNS-C stated they did not check the box located in the assessment template, that indicated if the residents listed above were or were not at risk to be abused. LALD/CNS-C stated R1 was not at risk to abuse others. The surveyor inquired why R1 was not at risk to abuse others. LALD/CNS-C stated R1 could become aggressive during their manic phase but R1 had not exhibited aggression at the facility. The surveyor inquired if R1 had a history of sexually abusing others. LALD/CNS-C stated yes R1 did have a history but the licensee had not seen any issue with abuse since admission. The licensee's Individual Abuse Prevention Plan policy dated August 1, 2021, indicated the IAPP would contain and individualized review or assessment of the person's susceptibility to abuse by another individual including: - other vulnerable adults; - the person's risk of abusing other vulnerable adults; and - statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		

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0 650	Continued From page 7	0 650		
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records included all required content for three of three employees (unlicensed personnel (ULP)-A, ULP-B, ULP-E). 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	0 650		

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0 650	Continued From page 8 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 June 1, 2026, at 11:26 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated R1 resided at the facility for a portion of the year and the other portion R1 resided in the community in their own home. On June 2, 2026, at 2:27 p.m., LALD/CNS-C stated R1 used inhalers and topical medication while at the facility. In addition, LALD-D stated most ULP knew how to apply topical medication except for diclofenac gel due to that medication's dosing. R1's Med Admin Summary - Month dated May 2026 included inhalers and topical medications which indicated employees who worked with R1 would need to administer the medications when R1 was present at the facility. ULP-A ULP-A was hired to the parent company of the licensee on May 24, 2021, and began providing assisted living services for the licensee when the first resident admitted on February 5, 2025. ULP-A's Oral Medication Administration Competency dated July 7, 2025, did not include a competency evaluation for inhalers and topical medications. ULP-A's record lacked a competency evaluation for topical medication and inhalers.	0 650		

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0 650	Continued From page 9 ULP-B ULP-B was hired on February 11, 2026, and began providing assisted living services. ULP-B's undated Unlicensed Personnel Competency/Skill Evaluation included the following competency evaluations: - appropriate and safe techniques in person hygiene and grooming which included: - hair care and bathing; - care of teeth, gums, and oral prosthetic devices; - dressing and assisting with toileting; - standby assistance techniques and how to perform them; - safe transfer techniques and ambulation; and - range of motion and positioning. The document was signed by ULP-B however, the document lacked the following information: - date each competency evaluation was completed, if ULP-B was deemed competent, the registered nurse (RN) initials on the skill completed, the method of training, and the RN signature. ULP-B's Oral Medication Administration Competency dated February 16, 2026, was signed by ULP-B, however, it lacked if ULP-B passed or failed the competency and lacked a RN signature. ULP-B Medication Setup for Residents Going on Leave of Absence was signed on February 16, 2026, by ULP-B, however, lacked an RN signature. ULP-B's record lacked a competency evaluation for topical medication and inhalers. ULP-E ULP-E was hired on November 4, 2025, and	0 650		

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0 650	Continued From page 10 began providing assisted living services. ULP-E's undated Unlicensed Personnel Competency/Skill Evaluation included the following competency evaluations: - appropriate and safe techniques in person hygiene and grooming which included: - hair care and bathing; - care of teeth, gums, and oral prosthetic devices; - dressing and assisting with toileting; - standby assistance techniques and how to perform them; - safe transfer techniques and ambulation; and - range of motion and positioning. The document was signed by ULP-E however, the document lacked the following information: - date the competency evaluation was completed, if ULP-E was competent, the RN initials on the skill completed, the method of training, and the RN signature. ULP-E's undated Oral Medication Administration Competency lacked the following: a date it was completed, a signature from ULP-E, if ULP-E passed or failed the competency, and a RN signature. ULP-E's Medication Setup for Residents Going on Leave of Absence was signed on November 4, 2025, by ULP-E, however lacked an RN signature. ULP-E's record lacked a competency evaluation for topical medication and inhalers. On June 2, 2026, at 8:58 a.m., ULP-A stated they were trained and completed a return demonstration to the nurse for inhalers and topical medications.	0 650		

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0 650	Continued From page 11 On June 2, 2026, at 9:15 a.m., ULP-B stated they were trained and completed a return demonstration to the nurse for inhalers and topical medications. In addition, ULP-B stated they were trained and completed a return demonstration on the topics listed above. On June 2, 2026, at 2:27 p.m., LALD/CNS-C stated they completed training and a return demonstration with ULP on inhalers during a staff meeting. LALD/CNS-C stated they would provide the surveyor with the documentation of the training. The surveyor did not receive the training document prior to the completion of the survey. On June 2, 2026, at 2:40 p.m., LALD/CNS-C stated they completed the competency evaluation listed above with ULP-B. LALD/CNS-C stated after they complete a training or competency evaluation, they had the ULP sign the form and then began the next training or competency evaluation. LALD/CNS-C stated after the training or competency evaluation they went back to the form and completed their portion of the document. LALD/CNS-C stated they believed they missed going back to fill in the information on the document for ULP-B. On June 2, 2026, at 9:09 a.m., the surveyor inquired why ULP-E's competency evaluations were not filled in with the required information listed above. LALD/CNS-C stated "Oh my gosh. Yeah, she was here briefly. Yeah, I see it is just a oversite." On June 3, 2026, at 10:58 a.m., ULP-E stated they were trained and completed a return demonstration to the nurse for inhalers and topical medications. In addition, ULP-E stated	0 650		

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0 650	Continued From page 12 they were trained and completed a return demonstration on the topics listed above. Minnesota Administrative Rules 4659.0190 Training Requirements dated August 11, 2021, read, "Subp. 6. Training records and documentation. A. The facility must maintain a record of staff training and competency required under this part and Minnesota Statutes, chapter 144G, that documents the following information for each competency evaluation, training, retraining, and orientation topic: (1) facility name, location, and license number; (2) name of the training topic or training program, and the training methodology, such as classroom style, web-based training, video, or one-to-one training; (3) date of the training and competency evaluation, and the total amount of time of the training and competency evaluation; (4) name and title of the instructor and the instructor's signature, and the name and title of the competency evaluator, if different from the instructor, and the evaluator's signature with a statement attesting that the employee successfully completed the training and competency evaluation; and (5) name and title of the staff person completing the training, and the staff person's signature with a statement attesting that the staff person successfully completed the training as described in the training documentation. B. Documentation of the completed competency evaluation, training, retraining, or orientation must be provided to the employee at the time the evaluation or training is completed." The licensee's 4.05 Employee Records policy dated August 1, 2021, indicated employee	0 650		

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0 650	Continued From page 13 records would include records of all training and in-service education required and/or provided including record of competency testing as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule.	0 680		

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0 680	Continued From page 14 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 Emergency Preparedness Assisted Living binder dated June 2021, lacked evidence of the following required content: - quarterly missing resident plan review; - sewage and waste disposal; - procedures for tracking of staff and residents; - transportation used for an evacuation; - roles under a waiver declared by secretary; and - emergency prep testing. On June 3, 2026, at 9:09 a.m., licensed assisted director/clinical nurse supervisor (LALD/CNS)-C stated they reviewed the missing resident plan every six months in May and November. LALD/CNS-C stated they believed they had something in the EPP that would address sewage and waste disposal and would provide it to the surveyor if they located it. LALD/CNS-C stated they tracked residents and staff by having them meet at the end of the driveway because it was a	0 680		

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0 680	Continued From page 15 small facility. LALD/CNS-C stated they used Residex (a documentation software) and the sign in and out book to know which residents were located at the facility. LALD/CNS-C stated they would provide the surveyor with a document of how staff and residents were tracked if they could locate it. LALD/CNS-C stated they did not know what waivers declared by secretary were. LALD/CNS-C stated they completed elopement drills at the facility and would locate them and provide them to the surveyor. The surveyor did not receive the documents listed above that LALD/CNS-C stated they would provide to the surveyor prior to the completion of the survey. The licensee's 9.01 Emergency Preparedness Plan - Appendix Z Compliance dated August 1, 2021, indicated the licensee's emergency preparedness plan would include all required elements of appendix Z. The plan would be in writing and reviewed annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 775 SS=E	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, record review, and interview, the licensee failed to ensure the physical environment of the facility was	0 775		

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0 775	Continued From page 16 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). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated June 1, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 780 SS=E	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a	0 780		

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0 780	Continued From page 17 dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, 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). The findings include: Please refer to the document titled, Physical	0 780		

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0 780	Continued From page 18 Environment Inspection Report (PEIR) dated June 1, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 790 SS=E	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, 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	0 790		

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0 790	Continued From page 19 than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated June 1, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
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	0 810		

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0 810	Continued From page 20 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 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, record review, and interview, 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 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, Physical Environment Inspection Report (PEIR) dated June 1, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one	0 810		

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0 810	Continued From page 21 (21) days	0 810		
01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family;	01370		

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01370	Continued From page 22 (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure required competency evaluations were completed for all required skill areas, prior to providing services for two of three unlicensed personnel ((ULP)-B, ULP-E). 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-B ULP-B was hired on February 11, 2026, and began providing assisted living services. R2's Med Admin Summary - Actual - Month dated April 2026 indicated ULP-B administered medication to R2 on April 7, 2026. ULP-E ULP-E was hired on November 4, 2025, and began providing assisted living services. On June 3, 2026, at 9:09 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated ULP-E provided services to	01370		

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01370	Continued From page 23 residents who previously resided at the facility. ULP-B and ULP-E's personnel file lacked a competency evaluation related to care and use of hearing aids. On June 2, 2026, at 9:15 a.m., ULP-B stated they did not receive a competency evaluation related to hearing aids. On June 3, 2026, at 9:25 a.m., LALD/CNS-C stated ULP received hearing aid training via EduCare (a training software program) however, the licensee did not complete competency evaluations with ULP on hearing aids unless the facility had a resident who utilized a hearing aid. LALD/CNS-C stated they had not had a resident with hearing aids, so unless the ULP worked at a different licensee under the parent company that had a resident with hearing aid, they would not have received a competency evaluation on hearing aids. The licensee's 5.02 Competency Training Evaluations policy dated August 1, 2021, indicated training and competency evaluations for all ULPs would include care and use of hearing aids. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01530 SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and	01530		

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01530	Continued From page 24 de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter;	01530		

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01530	Continued From page 25 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide two hours of initial training, related to mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8) for three of three employees (unlicensed personnel (ULP)-A, ULP-B, ULP-E). 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-A was hired to the parent company of the licensee on May 24, 2021, and began providing assisted living services for the licensee when the first resident admitted on February 5, 2025. ULP-A's EduCare (a training software program) transcript included Mental Illness Response Strategies completed on January 30, 2026, and Mental Illness-response Strategies completed June 2, 2025. The courses provided 1.75 hours of mental health training. ULP-A's record lacked 15 minutes of mental health training. On June 2, 2026, at 8:58 a.m., ULP-A stated they have provided services to R1. ULP-B ULP-B was hired on February 11, 2026, and	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41244	A. BUILDING: _____ B. WING _____	06/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JUDE HOME HEALTH LLC	11261 WEST RIVER ROAD CHAMPLIN, MN 55316

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01530	Continued From page 26 began providing assisted living services. R2's Med Admin Summary - Actual - Month dated April 2026 indicated ULP-B administered medication to R2 on April 7, 2026. ULP-B's EduCare transcript included Mental Illness Response Strategies completed on May 31, 2026, and Mental Illness-response Strategies completed February 27, 2026. The courses provided 1.75 hours of mental health training. ULP-B's record lacked 15 minutes of mental health training. ULP-E ULP-E was hired on November 4, 2025, and began providing assisted living services. ULP-E's EduCare transcript included Mental Illness Response Strategies and Mental Illness-response Strategies completed January 4, 2026. The courses provided 1.75 hours of mental health training. ULP-E's record lacked 15 minutes of mental health training. On June 2, 2026, at 2:37 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated mental health training was a new regulation that just went into effect, and they believed they provided three hours of mental health training. LALD/CNS-C stated the EduCare program was set up with all of the required courses for assisted living and when they inputted an employee into the system it would assign them the required courses, however, since mental health was a new regulation, they had to go into the system and manually input all of the mental health courses. The surveyor inquired why the ULP listed above did not receive the two initial hours for mental health. LALD/CNS-C stated	01530		

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01530	Continued From page 27 "yeah, your right. I am sorry. I thought I had it in." On June 3, 2026, at 9:09 a.m., LALD/CNS-C stated ULP-E provided services to residents who previously resided at the facility. The licensee's policies and procedures did not include a policy that addressed mental illness and de-escalation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of	01640		

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01640	Continued From page 28 the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to finalize a current written service plan that included a signature or other authentication by the facility and by the resident documenting an agreement on the services to be provided for one of three residents (R2). 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: R3 was admitted to the licensee on February 13, 2026, and began receiving assisted living services. R3 discharged from the licensee on April 20, 2026. R3's diagnoses included hypertension (HTN) and diabetes. R3's Service Plan (Waiver) - Addendum to Contract signed April 16, 2026, did not list services that would be provided to R3. R3's service plan lacked services to be provided to R3. On June 3, 2026, at 9:09 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated service plans were reviewed with residents then signed.	01640		

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01640	Continued From page 29 On June 3, 2026, at 9:29 a.m., LALD/CNS-C stated R3 received medication management including medication administration, behavior management, and housekeeping. LALD/CNS-C stated R3 would frequently refuse services, especially when they were under the influence. The surveyor inquired about why the services were not included on the service plan. LALD/CNS-C stated "huh" and that they would look for another service plan for R3. On June 3, 2026, at 3:56 p.m., via email, the surveyor received an additional service plan for R3. The service plan titled Service Plan (Waiver) - Addendum to Contract dated May 20, 2026, indicated R3 received assistance for appointments, grooming, housekeeping, laundry, behavior management, meals, medication administration, medication set up, vital signs, safety checks, and shopping. The document was not signed by the licensee or R3. The licensee's 6.08 Service Plan policy dated June 2024 indicated the service plan and any revision shall include a signature or other authentication by the licensee and by the resident, or resident's representative documenting an agreement on the services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01760 SS=E	144G.71 Subd. 8 Documentation of administration of medication	01760		

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01760	Continued From page 30 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 interview and record review, the licensee failed to document each medication administered by the assisted living facility staff or failed to document why the medication administration was not completed as prescribed for two of three residents (R1, R2). 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 was admitted to the licensee on February 22, 2025, and began receiving assisted living	01760		

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01760	Continued From page 31 services. R1's diagnoses included bipolar disorder (mental health condition characterized by significant mood swings, including manic episodes and depressive episodes), arthritis, chromic obstructive pulmonary disease (COPD), and diabetes. R1's Service Plan (Waiver) - Addendum to Contract signed February 24, 2025, indicated R1 received assistance with appointments, grooming, housekeeping, laundry, behavior management, meals, medication administration and set up, blood glucose monitoring, vital sign monitoring, safety check, and shopping. R1's Med Admin Summary - Month dated May 2026 lacked any documentation for the following medications/dates: - Anro Ellipta 62.5 -25 micrograms (mcg) inhaler at 9:00 a.m. on May 1, and 2, 2026; - aspirin 81 milligrams (mg) chewable tablet at 9:00 a.m. on May 1, and 2, 2026; - bupropion hydrochloride (HCL) 100 mg at 9:00 a.m. on May 1, and 2, 2026; - one daily-vite tablet at 9:00 a.m. on May 1, and 2, 2026; - fish oil 1000 mg at 9:00 a.m. on May 1, and 2, 2026; - levothyroxine sodium 125 mcg at 9:00 a.m. on May 1, and 2, 2026; - meloxicam 7.5 mg at 9:00 a.m. on May 1, and 2, 2026; - metformin 1000 mg at 9:00 a.m. on May 1, and 2, 2026; - propranolol 40 mg at 9:00 a.m. on May 1, and 2, 2026; - diclofenac sodium 1 percent (%) gel at 12:00 p.m. and 4 p.m. on May 1, 2026, and 12:00 p.m. on May 2, 2026;	01760		

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01760	Continued From page 32 - divalproex sodium 1500 mg at 6:00 p.m. on May 1, 2026; - lidocaine 5 % at 8:00 p.m. on May 1, 2026; - atorvastatin 80 mg at 8:00 p.m. on May 1, 2026; - bupropion HCL 100 mg at 9:00 p.m. on May 1, 2026; - metformin 1000 mg at 9:00 p.m. on May 1, 2026; - nicotine 14 mg patch at 9:00 p.m. on May 1, 2026; and - propranolol 40 mg at 9:00 p.m. on May 1, 2026. R2 R2 was admitted to the licensee on December 23, 2025, and began receiving assisted living services. R2 discharged from the licensee on April 21, 2026. R2's diagnoses included chronic heart failure (CHF). R2's Service Plan (Waiver)- Addendum to Contract signed December 26, 2025, indicated R2 received assistance with behavior management, medication administration, and vital sign monitoring. R2's Med Admin Summary -Actual - Month dated April 2026 lacked any documentation for the following medications/dates: - carvedilol 12.5 mg at 8:00 p.m. on April 18, 2026; - nicotine 14 mg patch at 8:00 p.m. on April 18, 2026; and - sacubitril-valsartan 97mg -103mg at 8:00 p.m. on April 18, 2026. On June 3, 2026, at 9:34 a.m., the surveyor inquired if R2 received their medication at 8:00 p.m. on April 18, 2026. Licensed assisted living	01760		

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01760	Continued From page 33 director/clinical nurse supervisor (LALD/CNS)-C stated, "it's blank" and they were unable to find any documentation if the medication was provided or refused by R2. LALD/CNS-C stated they trained their staff to document if medications were or were not given on Residex (a documenting software program). LALD/CNS-C stated if R2 was not there when they attempted to administer the medication they would have provided it them when they returned. LALD/CNS-C stated R1 went out of the building frequently to live at their other place of address. LALD/CNS-C stated when R1 was out of the building Residex took the resident out of the system and there was no way to document on them. The surveyor inquired if they had documentation of when they were gone or if medication was sent with the residents. LALD/CNS-C stated they had documentation of the medication being sent to R1. On June 4, 2026, at 1:12 p.m., via email, the surveyor received Medications Sent Out of Facility dated May 22, 2026. The document did not address the dates listed above for R1. The licensee's 7.22 Medication & Treatment Record - Documentation & Refusal policy dated August 1, 2021, indicated medication administration must be documented in the resident's medication record after providing medication administration or assistance. In addition, if a medication was not administered as prescribed documentation must be completed and include the reason why it was not completed and any follow up procedure that were provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01760		

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01760	Continued From page 34 days	01760		
01820 SS=E	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for two of three residents (R1, R2). 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 was admitted to the licensee on February 22, 2025, and began receiving assisted living services. R1's diagnoses included bipolar disorder (mental health condition characterized by significant mood swings, including manic episodes and depressive episodes), arthritis, chronic obstructive pulmonary	01820		

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01820	Continued From page 35 disease (COPD), and diabetes. R1's Service Plan (Waiver) - Addendum to Contract signed February 24, 2025, indicated R1 received assistance with appointments, grooming, housekeeping, laundry, behavior management, meals, medication administration and set up, blood glucose monitoring, vital sign monitoring, safety check, and shopping. R1's Med Admin Summary - Month dated May 2026 included melatonin 3 mg at bedtime and Metamucil psyllium husk fiber supplement take one tablet daily as needed (PRN). R1's record lacked signed prescriber's orders for the medications listed above. R2 R2 was admitted to the licensee on December 23, 2025, and began receiving assisted living services. R2 discharged from the licensee on April 21, 2026. R2's diagnoses included chronic heart failure (CHF). R2's Service Plan (Waiver)- Addendum to Contract signed December 26, 2025, indicated R2 received assistance with behavior management, medication administration, and vital sign monitoring. R2's Med Admin Summary -Actual - Month dated April 2026 included Farxiga 10 mg daily. R2's record lacked a signed prescriber order for the medication listed above. On June 3, 2026, at 9:51 a.m., licensed assisted	01820		

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01820	Continued From page 36 living director/clinical nurse supervisor (LALD/CNS)-C stated the licensee obtained a majority of their residents medication orders via fax from the pharmacy after the prescriber had sent the prescription to the pharmacy and then they entered the medication into the medication administration record. LALD/CNS-C stated were having issues obtaining some of R1's orders due to R1 not being at the facility more than half of the year, R1 missing medical appointments, and prescribers unwilling to write new prescriptions due to R1 not being seen for an extended period of time. LALD/CNS-C stated they were frustrated with the situation as prescribers were unwilling to collaborate for R1's needs due to circumstances. The licensee's 7.15 Medication & Treatment -Administration & Delegation policy dated August 1, 2021, indicated prior to a ULP providing delegated medication administration the medication must have a current prescriber order on file. The licensee's 7.20 Medication & Treatment Orders policy dated August 1 2021, indicated the registered nurse (RN) was responsible for assuring a current, authorized prescriber orders for medication administered by the staff were kept on file in the residents records. The licensee's undated Medication Management Program policy read, "[the licensee] will not administer any medication to resident without a physician's prescription for that medication." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		

St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

ST JUDE HOME HEALTH LLC
11261 West River Road
Champlin, MN 55428
Hennepin County
Parcel:

Phone:

License Info

License: HFID 41244

Risk:
License:
Expires on:
CFPM: Hannah Y. Abumayaleh
CFPM #: 124463; Exp: 8/5/2027

Inspection Info

Report Number: F1051261147
Inspection Type: Full - Single
Date: 6/1/2026 Time: 10:35:00 AM
Duration: 30 minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 1
Total Priority 3 Orders: 1
Delivery: Emailed

New Order: 4-300 Equipment Numbers and Capacities
4-302.14 *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.
COMMENT:
PROVIDE A TEST KIT FOR THE DISHMACHINE.
Comply By: 6/8/2026 Originally Issued On: 6/1/2026

New Order: 6-300 Physical Facility Numbers and Capacities
6-301.14A *Priority Level: Priority 3 CFP#: 10*
MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands.
COMMENT:
AT THE TIME OF INSPECTION, THE RESTROOM ON THE MAIN FLOOR DOES NOT HAVE AN EMPLOYEE HANDWASH SIGN.
Comply By: 6/1/2026 Originally Issued On: 6/1/2026

Food & Beverage General Comment

MET WITH THE NURSE EVALUATOR, ASHLEY CREWS.

DISCUSSED THE FOLLOWING WITH THE MANAGER, DOTTY:

EMPLOYEE ILLNESS LOG
VOMIT CLEAN-UP PROCEDURES
HANDWASHING & GLOVE USE/DISPOSAL
NOROVIRUS

THE KITCHEN HAS A NSF 184 DISHMACHINE, LAMINATE CABINETS, STONE MATERIAL COUNTERTOPS WITH HOLLOW BASES, ORANGE PEEL TEXTURE CEILING, AND LUXURY VINYL PLANK FLOORS.

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 St Cloud District Office inspection report number F1051261147 from 6/1/2026

Dotty
Manager

Kai Yang,
Public Health Sanitarian 1
320-640-3532
kai.yang@state.mn.us

St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301

Temperature Observations/Recordings

Establishment Info

ST JUDE HOME HEALTH LLC
Champlin
County/Group: Hennepin County

Inspection Info

Report Number: F1051261147
Inspection Type: Full
Date: 6/1/2026
Time: 10:35:00 AM

Equipment Temperature: Product/Item/Unit: AMBIENT**; Temperature Process:** Ambient Air
Location: Upright Cooler at 36 Degrees F.
Comment:
Violation Issued?: No

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL41244015-0	**Date:** June 1, 2026
Facility Name: ST JUDE HOME HEALTH LLC	
Facility Address: 11261 WEST RIVER ROAD, CHAMPLIN, MN 55316	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 2; Pattern **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. Required egress window openings in rooms of care facilities licensed or registered by the state of Minnesota shall have a minimum net clear opening area of 4.5 square feet (648 square inches). Opening height and width dimensions shall not be less than 20 inches. The net clear opening dimensions shall be the result of normal operation of the opening. [Minn. Stat. 144G.45 subd. 2; MSFC 1104.26.2, 1104.26.6.1]

   Comments: Licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C opened the egress window ninety degrees in unoccupied resident sleeping room one and the clear open area was measured by the surveyor. The open area of the egress window measured 17 inches width, 35.5 inches height, with a total clear area of 603.5 square inches. When the egress window open width was adjusted to 20 inches, the clear open angle width measured 17 inches. During the facility tour interview, LALD/CNS-C verified the egress window measurements. The egress window did not provide an unobstructed opening with a minimum area of 4.5 square feet.

3. A means of egress shall be free from obstructions that would prevent its use. [Minn. Stat. 144G.45 subd. 2; MSFC 1031.3]

   Comments: In unoccupied resident room three, the window blind installed at the top of the egress window obstructed removal of the screen. When screens are installed on egress windows, the screen must be releasable using normal, standard operating force.

4. Extension cords and flexible cords shall not be a substitute for permanent wiring and shall be listed and labeled in accordance with UL 817. Extension cords and flexible cords shall not be affixed to structures,

extended through walls, ceilings or floors, or under doors or floor coverings, nor shall such cords be subject to environmental damage or physical impact. [Minn. Stat. 144G.45 subd. 2; MSFC 604.5]

Comments:
- An extension cord was used to supply power to a refrigeration unit in the breezeway, and this cord ran across the floor under the doorway.
- An extension cord was used in the laundry room to supply power to an electronic monitoring system.
- Extension cords were used to supply power to personal electronics in the walk-in-closet of occupied resident room four.
- In the attached garage, an extension cord was taped to electrical conduit and plugged into a light fixture installed on the ceiling.

☒ **TAG IDENTIFICATION: 0780**

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

1. Smoke alarms shall be interconnected so that actuation of one alarm causes all alarms in the individual dwelling or sleeping unit to operate where more than one smoke alarm is required within an individual dwelling or sleeping unit. [Minn. Stat. 144G.45 subd.2]

   Comments:
   - The smoke alarm for unoccupied resident room two had been removed from the ceiling bracket and was stored on top of an end table. Licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated the alarm had been taken down because it was chirping. The smoke alarm was reinstalled while the surveyor was onsite.
   - LALD/CNS-C stated new wireless smoke alarms had been installed to meet the statute requirements. When LALD/CNS-C tested the wireless smoke alarm system, there were several extra battery operated smoke alarms installed in the building that were not actuated. LALD/CNS-C stated these extra battery operated smoke alarms were pre-existing and would be removed as they were not part of the new wireless interconnected system. All dwelling unit smoke alarms were not interconnected.

☒ **TAG IDENTIFICATION: 0790**

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

1. Portable fire extinguishers installed and maintained to MN State Fire Code. [Minn. Stat. 144G.45 subd.2]

Comments: Two portable fire extinguishers were stored on a table in the main floor living room. Licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C explained these fire extinguishers had been removed from the brackets for annual maintenance completed in May.

☒ **TAG IDENTIFICATION: 0810**

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

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1. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that are readily available at all times within the facility. [Minn. Stat. 144G.45 subd.2]

   Comments: The emergency exit floor plans that identified the location of resident rooms were not displayed in common areas of the building.

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

   Comments:
   - The licensee failed to develop the fire safety and evacuation plan (FSEP) with employee actions relative to the facility's building layout and environmental risks. The FSEP included a 9.06 fire policy dated August 1, 2024, and an undated emergency plan for fire that were templates from a third party.
   - The fire policy inaccurately referenced smoke compartment doors, a fire sprinkler system, and fire doors on magnetic door holders. This policy was developed for buildings with fire resistant construction and life safety systems.
   - The emergency plan for fire included general employee procedures but lacked site specific employee actions.
   - Employees were directed to fire extinguisher locations that were not accurate on the emergency exit floor plans.
   - The FSEP inaccurately referenced pull fire alarms.
   - The FSEP floor plans in the emergency preparedness binder inappropriately labeled a window as an emergency exit inside the walk-in closet of occupied resident room 4. Licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C explained a new egress window had been installed in resident bedroom four during the plan review process and was designed as the emergency escape window. All copies of the FSEP floor plans shall accurately identify the location of egress windows to provide efficient communication for exiting in the event of a fire or similar emergency.

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

Comments: The licensee failed to develop site specific fire safety and evacuation instructions for residents evident by the lack of these procedures in the plan.

3. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) 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 emergency evacuation report dated December 24, 2025, indicated two residents were living at the facility and both required employee assistance in the event of an emergency evacuation. The current resident census was one. The fire safety and evacuation plan shall be accurately maintained to provide efficient communication for evacuation in the event of a fire or similar emergency.

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

   Comments: The surveyor requested records for employee training on the fire safety and evacuation plan (FSEP) at the time of hire. An orientation checklist dated February 16, 2026, was provided that did not list FSEP training. Licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated FSEP training was completed during the emergency preparedness policy and procedures orientation recorded on this checklist. Documentation was not provided to support FSEP training had been completed at the time of hire.

5. Evacuation drills are required for employees 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. [Minn. Stat. 144G.45 subd.2]

   Comments: The surveyor requested records for evacuation drills completed for the past year from licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C. Fire drill schedules were provided for 2025 and 2026 indicating drills were completed in February and April of 2026 and in February, April, and June of 2025. The evacuation drill frequency was not met. Additionally, the fire drill reports lacked simulated fire locations and drill conditions.