Electronically Delivered

October 22, 2026

Licensee
Terrace Haven Care LLC
1220 Lincoln Terrace Northeast
Columbia Heights, MN 55421

RE: Project Number(s) SL42941001

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 September 29, 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.

The Department of Health 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. 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:
https://forms.web.health.state.mn.us/form/HRDAppealsForm.

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

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

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

If you have any questions, please contact me.

Sincerely,

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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	42941	A. BUILDING: _____ B. WING _____	09/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRACE HAVEN CARE LLC	1220 LINCOLN TERRACE NE COLUMBIA HEIGHTS, MN 55421

(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: SL42941001-0 On September 28, 2026, through September 29, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were four (4) residents; 4 receiving services under the Provisional Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated September 28, 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		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included baseline TB screening and testing for three of three employees (unlicensed personnel (ULP)-C, ULP-D, ULP-F). 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	0 660		

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0 660	Continued From page 4 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: The licensee's Facility TB Risk Assessment form was completed August 1, 2026, and identified the facility TB risk level as low. ULP-C ULP-C was hired on August 1, 2026, and began providing assisted living services. ULP-C's employee record included an undated Health Care Personnel (HCP) Baseline Individual TB Risk Assessment. The assessment form lacked assessment of TB symptoms or history data. ULP-C's record included an undated TB Blood Test form indicating ULP-C had a QuantiFERON TB blood test drawn on August 30, 2026. The record lacked the laboratory results of ULP-C's TB test. ULP-D ULP-D was hired on August 20, 2026, and began providing assisted living services. ULP-C's employee record included an undated HCP Baseline Individual TB Risk Assessment. The assessment form lacked assessment of TB symptoms or history data. ULP-D's employee record lacked results of a tuberculin skin test (TST) or TB blood test. ULP-F	0 660		

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0 660	Continued From page 5 ULP-F was hired August 29, 2026, and began providing assisted living services. ULP-F's employee record included a HCP Baseline Individual TB Risk Assessment dated August 20, 2026. The assessment form lacked assessment of TB symptoms or history data. ULP-F's employee record included a negative QuantiFERON Gold TB blood test dated December 17, 2025. The blood test was taken more than 90 days prior to ULP-F's date of hire. On September 28, 2026, at 2:33 p.m., clinical nurse supervisor (CNS)-B stated she understood that a TB blood test only needed to be done one time and did not need to be repeated if the result was negative. CNS-B stated they had previously used the Baseline TB Screening Tool for Health Care Workers (HCW) from the Minnesota Department of Health (MDH) and had changed to using the current tool from the CDC. The licensee's 8.16 Tuberculosis Screening policy dated August 4, 2026, indicated staff screening would be conducted as follows: -new staff would be screened for active signs of TB using the Baseline Screening Tool for HCWs; -new staff would have a TB blood test or a two-step TST conducted with results documented on the Baseline Screening Tool for HCWs; and -no staff would be permitted to begin work where the work involved sharing the air space with residents until the negative results of the first TST were read and documented, or a negative TB blood test was received and documented. The MDH guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, indicated baseline TB	0 660		

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0 660	Continued From page 6 screening is indicated for all health care workers and consists of three components: -assessing current symptoms of active TB; -assessing TB history; and -testing for the presence of infection by administering either a two-step TST or a single TB blood test. The MDH guidelines also indicated that an employee may begin working with patients after a negative TB symptom screen and a negative TB blood test or TST (first step) dated within 90 days before hire. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
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	0 680		

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0 680	Continued From page 7 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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents receiving services under the provisional assisted living license. 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 EPP dated June 16, 2026, lacked the following required content: -development of a Hazard Vulnerability Assessment (HVA); -description of the resident population, including risks and specific needs of the residents in the facility; -process for emergency preparedness collaboration with state and local emergency planning authorities to engage in collaborative	0 680		

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0 680	Continued From page 8 planning to an integrated emergency response. -policies and procedures for development of EPP based on the facility and community-based risk assessments and communication plan, utilizing an all-hazards approach; -policies and procedures for subsistence needs for staff and residents, including provision of food, water, medical and pharmaceutical supplies; -policies and procedures for tracking staff and residents; -policies and procedures including evacuation; -policies and procedures for medical documents; -policies and procedures for volunteers; -development of a communication plan to include: -names and contact information; -primary and alternate means for communication; -methods for sharing information; -procedure for sharing information on occupancy and or needs; -long term care family notifications; On September 28, 2026, at 11: 15 a.m., during a facility tour, owner (O)-A stated they did not keep additional food or water supplies in the event of an emergency. On September 29, 2026, at 1:30 p.m., clinical nurse supervisor (CNS)-B stated they were unaware there was required content missing from the facility's EPP. CNS-B stated she thought she had completed the HVA. CNS-B also stated they had not completed an EPP drill or tabletop exercise. The licensee's 9.01 Emergency Preparedness Plan - Appendix Z Compliance policy dated August 4, 2026, indicated the licensee would have an EPP that would include all the required elements of appendix Z.	0 680		

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0 680	Continued From page 9 Minnesota Administrative Rule 4659.0100 dated August 11, 2021, indicated assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.72, or successor requirements. This part referenced documents, specifications, methods, and standards in State Operations Manual Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types: Interpretive Guidance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or	0 730		

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0 730	Continued From page 10 conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure resident records included documentation of services provided for two of two residents (R2, R3). 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	0 730		

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0 730	Continued From page 11 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 R2 was admitted on August 31, 2026, and began receiving assisted living services. R2's Addendum to Contract (service plan) dated September 29, 2026, indicated R2's services included assistance with dressing, grooming, bathing, behavior management, medication, and blood glucose monitoring. R2's Service Recap Summary dated September 2026, lacked documentation of services provided for the following services and dates: -record blood glucose on September 12, 13, and 14; -assistance with dressing and grooming on September 6, 7, 8, 9, 10, 12, and 13; -assistance with behavior management on September 6, 7, 8, 9, 10, 12, and 13; -safety checks on September 6, 7, 8, 9, 10, 11, 12, 13, 16, 18, 19, 21, and 24; and -assistance with socialization on September 6, 7, 8, 9, 10, 11, 12, 13, 16, 17, 18, 21, and 24. R3 R3 was admitted on August 31, 2026, and began receiving assisted living services. R3's Addendum to Contract (service plan) dated September 29, 2026, indicated R3's services included assistance with bathing, dressing, grooming, medication administration, safety checks, and vital sign monitoring.	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	42941	A. BUILDING: _____ B. WING _____	09/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 730	Continued From page 12 R3's Service Recap Summary dated September 2026, lacked documentation of services provided for the following services and dates: -dressing, grooming, and bathing assistance on September 6, 7, 8, 9, 10, 12, and 13; -safety checks on September 6, 7, 8, 9, 12, 13, 18, and 19; and -activities and socialization on September 6, 7, 8, 9, 10, 11, 12, 13, 16, 18, 21, and 24. On September 29, 2026, at 1:30 p.m., clinical nurse supervisor (CNS)-B stated they were unaware that documentation was missing from R2 and R3's service logs. CNS-B stated they recently implemented Residex (electronic documentation system) and the documentation was still new to staff members. The licensee's 2.38 Resident Record-Information and Content policy dated August 4, 2026, indicated resident records would include documentation that services had been provided as identified in the service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
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:	0 775		

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0 775	Continued From page 13 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 Environment Inspection Report (PEIR) dated September 28, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
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	0 810		

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0 810	Continued From page 14 residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at 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 was issued at a widespread scope (when	0 810		

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0 810	Continued From page 15 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 September 28, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01320 SS=E	144G.60 Subd. 4 (a) Unlicensed personnel (a) Unlicensed personnel providing assisted living services must have: (1) successfully completed a training and competency evaluation appropriate to the services provided by the facility and the topics listed in section 144G.61, subdivision 2, paragraph (a); or (2) demonstrated competency by satisfactorily completing a written or oral test on the tasks the unlicensed personnel will perform and on the topics listed in section 144G.61, subdivision 2, paragraph (a); and successfully demonstrated competency on topics in section 144G.61, subdivision 2, paragraph (a), clauses (5), (7), and (8), by a practical skills test. Unlicensed personnel who only provide assisted living services listed in section 144G.08, subdivision 9, clauses (1) to (5), shall not perform delegated nursing or therapy tasks. This MN Requirement is not met as evidenced by:	01320		

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01320	Continued From page 16 Based on interview and record review, the licensee failed to ensure required training was completed and documented for two of three employees (unlicensed personnel (ULP)-C, ULP-F). 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 resident's 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: ULP-C was hired on August 1, 2026, and began providing assisted living services. ULP-F was hired on August 29, 2026, and began providing assisted living services. ULP-C and ULP-F's employee records lacked documentation of required training in communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's cultural background and family. On September 28, 2026, at 2:33 p.m., clinical nurse supervisor (CNS)-B stated they assigned the online training modules to staff and did not realize that required content was missing from the training assigned to ULP-C and ULP-F. The licensee's 5.02 Competency Training Evaluations policy dated August 4, 2026,	01320		

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01320	Continued From page 17 indicated training and competency evaluations for all ULPs would include communication skills that include preserving the dignity of the resident and showing respect for the resident's preferences cultural background, and family No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01320		
01330 SS=E	144G.60 Subd. 4 (b) Unlicensed personnel (b) Unlicensed personnel performing delegated nursing tasks in an assisted living facility must: (1) have successfully completed training and demonstrated competency by successfully completing a written or oral test of the topics in section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform; (2) satisfy the current requirements of Medicare for training or competency of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or 484.36; or (3) have, before April 19, 1993, completed a training course for nursing assistants that was approved by the commissioner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure required training was completed and documented for two of three employees (unlicensed personnel (ULP)-C,	01330		

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01330	Continued From page 18 ULP-F). 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 resident's 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: ULP-C was hired on August 1, 2026, and began providing assisted living services. ULP-F was hired on August 29, 2026, and began providing assisted living services. ULP-C and ULP-F's employee records lacked documentation of training in the following required content: -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; and -recognizing physical, emotional, cognitive, and developmental needs of the residents. On September 28, 2026, at 2:33 p.m., clinical nurse supervisor (CNS)-B stated they assigned the online training modules to staff and did not realize that required content was missing from the training assigned to ULP-C and ULP-F. The licensee's 5.02 Competency Training Evaluations policy dated August 4, 2026, indicated training and competency evaluations for	01330		

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01330	Continued From page 19 all ULPs would include the following required content: -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; and -recognizing physical, emotional, cognitive, and developmental needs of the residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01330		
01470 SS=E	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints;	01470		

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01470	Continued From page 20 (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received orientation to include all required content for two	01470		

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01470	Continued From page 21 of three employees (unlicensed personnel (ULP)-C, ULP-F). 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 resident's 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: ULP-C was hired on August 1, 2026, and began providing assisted living services. ULP-F was hired on August 29, 2026, and began providing assisted living services. ULP-C and ULP-F's employee records lacked documentation of orientation to include the following required content: -an overview of assisted living statutes; -an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; -the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services (DHS), county managed care advocates, or other relevant advocacy services;	01470		

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01470	Continued From page 22 and -a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. On September 28, 2026, at 2:33 p.m., clinical nurse supervisor (CNS)-B stated they assigned the online training modules to staff and did not realize that required content was missing from the orientation training assigned to ULP-C and ULP-F. The licensee's 5.01 Orientation of Staff and Supervisors and Content policy dated August 2, 2026, indicated that orientation would include the following topics: -an overview of the appropriate assisted living statutes and rules; -an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the staff person; -the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; Consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at DHS, county managed care advocates, or other relevant advocacy services; and -a review of the types of assisted living services the employee will be providing and the facility's category of licensure. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		

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01620	Continued From page 23	01620		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be	01620		

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01620	Continued From page 24 completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted ongoing resident monitoring and reassessment to include a reassessment completed within 14 days after the initiation of services for one of two 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: R2 was admitted on August 31, 2026, and began receiving assisted living services. R2's Addendum to Contract (service plan) dated September 29, 2026, indicated R2's services included assistance with dressing, grooming,	01620		

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01620	Continued From page 25 bathing, behavior management, medication administration, and safety checks. R2's record included a Uniform Assessment Tool form completed by clinical nurse supervisor (CNS)-B on August 20, 2026, and a consecutive nursing assessment completed on September 10, 2026, indicating R2's reassessment was completed 21 days after the initial assessment. On September 29, 2026, at 1:20 p.m., CNS-B stated they were unaware R2's assessment was completed after 14 days. CNS-B stated they were transitioning their documentation from a paper-based system to Residex (an electronic documentation system). The licensee's 6.01 Assessments, Reviews, and Monitoring policy dated August 4, 2026, indicated resident reassessment would be conducted no more than 14 calendar days after initiation of services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=F	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	01640		

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	42941	A. BUILDING: _____ B. WING _____	09/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01640	Continued From page 26 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 the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included a signature or other authentication by the resident or resident's designated representative to document agreement on the services to be provided for two of two residents (R2, R3). 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: R2 R2 was admitted to licensee on August 31, 2026, and began receiving assisted living services.	01640		

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01640	Continued From page 27 R2's record included a Service Plan from signed and dated August 20, 2026, indicating R2's Services included assistance with dressing, grooming, meal preparation, mobility, medication administration, blood glucose monitoring, safety checks, and behavioral management. R2's record included an Addendum to Contract (service plan) dated September 29, 2026, indicating addition of the following services: -activity assistance; -appointment assistance; -arranging transportation; -shopping assistance; -socialization; and -transfer assistance increased from as needed (PRN) to twice daily. R3 R3 was admitted on August 31, 2026, and began receiving assisted living services. R3's record included a Service Plan from signed and dated August 20, 2026, indicating R3's services included assistance with dressing, grooming, bathing, meal preparation, mobility, medication administration, blood glucose monitoring, safety checks, and assistance with appointments and transportation. R3's record included an Addendum to Contract (service plan) dated September 29, 2026, indicating revision of the following services: -addition of activity assistance; -addition of escort and mobility assistance; -addition of shopping assistance; -addition of socialization; and -removal of blood glucose monitoring. R2 and R3's service plans revised on September	01640		

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01640	Continued From page 28 29, 2026, lacked a signature or other authentication by the facility and by the residents, or resident's representative, documenting agreement on the services to be provided. On September 29, 2026, at 1:20 p.m., clinical nurse supervisor (CNS)-B stated they were aware of the signature or authentication requirement for service plans. CNS-B stated they were transitioning from a paper-based documentation system to an electronic system. The licensee's 6.08 Service Plan policy dated August 4, 2026, indicated the service plan and any revisions shall include a signature or other authentication by the licensee and by the resident, or resident's representative, documenting agreement on the services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01700 SS=D	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the	01700		

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01700	Continued From page 29 resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management assessment to include all required content for one of two residents (R3) who received medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on September 28, 2026, at 10:58 a.m., clinical nurse supervisor	01700		

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01700	Continued From page 30 (CNS)-B stated the licensee provided medication management services to all the licensee's residents. R3 was admitted to the licensee on August 31, 2026, and began receiving assisted living services. R3's Addendum to Contract (service plan) stated September 29, 2026, indicated R3's services included assistance with medication administration. R3's record included nursing assessments completed on August 20, 2026, September 2, 2026. R3's nursing assessments lacked the identification and review of all medications the resident is known to be taking, including indications for medications, side effects, contraindications, allergic or adverse reactions and actions to address these issues. On September 29, 2026, at 12:50 p.m., CNS-B stated they were unaware required content was missing from R3's medication assessment. CNS-B stated they were transitioning from a paper-based to an electronic documentation system. The licensee's 7.01 Medication Management - Assessment, Monitoring and Reassessment policy dated August 4, 2026, indicated the registered nurse would conduct a medication assessment prior to providing medication management services. The policy also indicated the assessment would include a review of all medications including side effects, indications for medications, contraindications, allergic or adverse reaction, and actions to address these issues.	01700		

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01700	Continued From page 31 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01760 SS=F	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 interview and record review, the licensee failed to document medication administration in resident records for two of two residents (R2, R3) and failed to document sliding scale insulin dosages administered for one of two 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 a widespread scope (when	01760		

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01760	Continued From page 32 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: R2 R2 was admitted to licensee on August 31, 2026, and began receiving assisted living services. R2's Addendum to Contract (service plan) dated September 29, 2026, indicated R2's services included assistance with medication administration and blood glucose monitoring. R2's Med Admin Summary (medication administration record (MAR)) dated September 2026, lacked documentation of medication administration for the following medications, dates and times: -Dexcom G7 (continuous blood glucose monitoring) sensor application on September 12 and 22; -aripiprazole 20 milligrams (mg) daily on September 12 and 13; -cetirizine 10 mg daily on September 12 and 13 at 8:00 a.m.; -duloxetine 30 mg twice daily on September 12 and 13, at 8:00 a.m., and September 12, 13, 19, 20, and 21, at 9:00 p.m.; -pregabalin 75 mg twice daily on September 12 and 13, at 8:00 a.m., and September 12, 13, 19, 20, and 21, at 9:00 p.m.; -rosuvastatin 20 mg daily on September 12 and 13, at 8:00 a.m.; -Senexon-S 8.6-50 mg twice daily on September 12 and 13, at 8:00 a.m., and September 12, 13, 19, 20, and 21, at 9:00 p.m.; -Lantus Solostar insulin 25 units at bedtime on	01760		

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01760	Continued From page 33 September 12 and 13, at 9:00 p.m.; and -Lispro Insulin three times daily per sliding scale on September 12 and 13, at 8:00 a.m., September 12, 13, 14, 15, 16, 18, 21, 23, and 25, at 4:00 p.m., and September 12, 13, 14, 19, 20, and 21, at 8:30 p.m. R2's Med Recap for a Single Med (Lispro Insulin) dated September 1, 2026, through September 29, 2026, indicated Lispro insulin had been administered to R2 and lacked documentation of the sliding scale dose on the following dates and times: -September 14, at 9:17 a.m.; -September 15, at 8:35 a.m., and 8:56 p.m.; -September 16, at 9:13 a.m., and 8:29 p.m.; -September 17, at 9:16 a.m., and 6:19 p.m.; -September 18, at 8:49 a.m.; -September 21, at 8:33 a.m.; -September 22, at 8:15 a.m., 6:45 p.m., and 8:35 p.m.; -September 24, at 8:16 a.m.; -September 25, at 8:28 a.m.; and -September 29, at 8:33 a.m. R3 R3 was admitted on August 31, 2026, and began receiving assisted living services. R3's Addendum to Contract (service plan) dated September 29, 2026, indicated R3's services included assistance with medication administration. R3's MAR dated September 2026, lacked documentation of medication administration for the following medications, dates and times: -diclofenac gel 1% to affected areas four times daily on September 16, 18, and 21 at 4:00 p.m., and September 12, 13, 19, 20, and 21, at 8:00	01760		

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01760	Continued From page 34 p.m.; -gabapentin 300 mg capsule, take two capsules twice daily on September 13, 18, and 21, at 5:00 p.m., and September 12, 13, 19, 20, and 21 at 8:00 p.m.; -metformin 500 mg tablet twice daily on September 13, 18, and 21, at 5:00 p.m.; -irbesartan 75 mg at bedtime on September 12, 13, 19, 20, and 21, at 8:00 p.m.; -mirtazapine 15 mg daily on September 12, 13, 19, 20, and 21, at 8:00 p.m.; -Cilostazol 50 mg twice daily on September 12, 13, 19, 20, and 21, at 9:00 p.m.; and -labetalol 200 mg daily on September 12, 13, 19, 20, and 21, at 9:00 p.m.; On September 29, 2026, at 11:32 a.m., clinical nurse supervisor (CNS)-B stated they were unaware that R2 and R3's MARS lacked documentation of medication administration. CNS-B stated they were unaware that staff were not documenting slicing scale insulin doses for R2, and stated staff "did not give sliding scale insulin all that often". The licensee's 7.22 Medication and Treatment Record - Documentation and Refusal policy dated August 4, 2026, indicated the following would be documented in the resident's medication record after providing medication assistance or administration: -date; -time; -quantity of dosage; -method of administration of all prescribed legend and over-the-counter medications; and -signature and title of the authorized person who provided the assistance or administration of medications. The policy also indicated if medication	01760		

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01760	Continued From page 35 administration was not completed as prescribed, documentation would include the reason why it was not completed and any follow up procedures that were provided. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01760		
01820 SS=F	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 two residents (R2, R3). 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: R2 R2 was admitted to licensee on August 31, 2026,	01820		

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01820	Continued From page 36 and began receiving assisted living services. R2's Addendum to Contract (service plan) dated September 29, 2026, indicated R2's services included assistance with medication administration and blood glucose monitoring. R2's Medication Administration Summary dated September 2026, indicated the following medications were administered to R2: -aripiprazole 20 milligrams (mg) on September 14, through September 28, 2026; -cetirizine 10 mg on September 17, through September 28, 2026; -duloxetine 30 mg on September 14, through September 28, 2026; -Lispro insulin sliding scale dose on September 14, 15, 16, 17, 18, 21, 22, 23, 24, 25, 26, and 27, 2026; -Mounjaro 5 mg on September 18 and 25, 2026; -pregabalin 75 mg on September 14 through September 28, 2026; -rosuvastatin 20 mg on September 14 through September 28, 2026; and -Lantus insulin 25 units on September 14, 15, and 16, 2026. R3 R3 was admitted on August 31, 2026, and began receiving assisted living services. R3's Addendum to Contract (service plan) dated September 29, 2026, indicated R3's services included assistance with medication administration. R3's Medication Administration Summary dated September 2026, indicated the following medications were administered to R3: -aripiprazole 5 mg on September 14 through	01820		

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01820	Continued From page 37 September 28, 2026; -atorvastatin 40 mg on September 14 through September 28, 2026; -cilostazol 50 mg on September 14 through September 28, 2026; -fluoxetine 80 mg on September 14 through September 28, 2026; -gabapentin 600 mg on September 14 through September 28, 2026; -Jardiance 10 mg on September 14 through September 28, 2026; -labetalol 200 mg on September 14 through September 28, 2026; -meloxicam 7.5 mg on September 14 through September 28, 2026; -metformin 500 mg on September 14 through September 28, 2026; -vitamin D3 25 micrograms (mcg) on September 14 through September 28, 2026; -irbesartan 75 mg on September 14, 15, 16, 17, 18, 22, 23, 24, 25, 26, and 27, 2026; and -mirtazapine 15 mg on September 14, 15, 16, 17, 18, 22, 23, 24, 25, 26, and 27, 2026. R2 and R3's records lacked a current written or electronically recorded prescription for all prescribed medications that licensee was managing for the residents. On September 29, 2026, at 11:32 a.m., clinical nurse supervisor (CNS)-B provided the surveyor with Outbound Transfer Form for R2, dated August 31, 2026, from Genoa pharmacy. The form listed R2's medications but lacked prescriber authentication. CNS-B stated they have reached out to all providers for medication orders but have not yet received them. The licensee's 7.20 Medication and Treatment Orders policy dated August 4, 2026, indicated	01820		

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01820	Continued From page 38 orders for medication must be dated, signed by the prescriber and must be current and consistent with the resident's nursing assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01870 SS=D	144G.71 Subd. 18 Medications provided by resident or family me When the assisted living facility is aware of any medications or dietary supplements that are being used by the resident and are not included in the assessment for medication management services, the staff must advise the registered nurse and document that in the resident record. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure all medications were included in the assessment for medication management or documented in the resident record for one of two 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:	01870		

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(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
01870	Continued From page 39 On September 28, 2026, at 10:58 a.m., during a tour of R2's room, the surveyor noted an open bottle of Aleve (pain reliever), an open bottle of vitamin D3 chewable gummies, and an open bottle of Hair, Skin, and Nails, chewable gummies on a shelf in the room. Clinical nurse supervisor (CNS)-B stated the licensee was not managing those medications for R2. R2 was admitted on August 31, 2026, and began receiving assisted living services. R2's Addendum to Contract (service plan) dated September 29, 2026, indicated R2's services included medication administration and assistance with behavior management for anxiety, self-isolation, self-injurious behaviors, and depression. R2's record lacked written or electronically signed physician orders for medications or treatment. R2's Uniform Assessment Tool dated August 20, 2026, lacked evidence of review of medications R2 was known to be taking. R2's Medication Assessment for Safety in Self-Administration dated August 20, 2026, indicated R2 was deemed able to partially safely self-administer creams, inhalers, and patches. R2's medication assessment lacked identification of self-administration of medications that were observed in R2's room. R2's nursing assessment dated September 10, 2026, indicated the registered nurse (RN) reviewed R2's current medication list, including prescription medications, over the counter (OTC) medications, and supplements. The assessment also indicated the medication list was compared	01870		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	42941	A. BUILDING: _____ B. WING _____	09/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRACE HAVEN CARE LLC	1220 LINCOLN TERRACE NE COLUMBIA HEIGHTS, MN 55421

(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
01870	Continued From page 40 with current provider healthcare orders and the medication administration record. The assessment also indicated that self-administration of medications was not applicable for R2. R2's Individualized Medication Management Plan (IMMP) dated August 20, 2026, indicated the licensee's staff would administer R2's medication. The IMMP lacked identification of medications to be self-managed or self-administered by R2. On September 29, 2026, at 1:35 p.m., CNS-B stated they had not yet developed a policy addressing OTC medications kept at the bedside. CNS-B stated they decided that OTC medications did not require physician orders and residents could store and manage their own OTC medications. The licensee's 7.14 Medications Provided by Residents or Others policy dated August 4, 2026, indicated that when licensee became aware of any medications or dietary supplements that are being used by the resident and are not included in the assessment for medication management services, the staff would advise the registered nurse and document in the resident record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01870		
01960 SS=F	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	42941	A. BUILDING: _____ B. WING _____	09/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRACE HAVEN CARE LLC	1220 LINCOLN TERRACE NE COLUMBIA HEIGHTS, MN 55421

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01960	Continued From page 41 record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document treatment administration for one of one resident receiving treatments (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 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: R2 was admitted to the licensee on August 31, 2026, and began receiving assisted living services. R2's Addendum to Contract (service plan) dated September 29, 2026, indicated R2's services included assistance with medication administration and blood glucose monitoring three times daily. R2's Service Recap Summary (service log) dated	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	42941	A. BUILDING: _____ B. WING _____	09/29/2026

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01960	Continued From page 42 September 2026, indicated R2 was to receive blood glucose monitoring three times daily (morning (a.m.), midday, and evening (p.m.)) R2's Vital Signs summary dated August 29, 2026, through September 29, 2026, lacked documentation of blood glucose monitoring results or the reason why it was not checked along with follow up procedures to meet the resident's needs; on the following dates and times: -September 16, 2026: missing p.m. result; -September 18, 2026: missing p.m. result; -September 21, 2026: missing p.m. result; -September 24, 2026: missing p.m. result; and -September 26, 2026, missing a.m., and midday results; On September 29, 2026, at 11:35 a.m., clinical nurse supervisor (CNS)-B stated they were unaware that R2's blood glucose results were not documented as ordered. CNS-B stated the documentation may have been missing as they were transitioning from a paper to an electronic medical record. The licensee's 7.22 Medication and Treatment Record - Documentation and Refusal policy dated August 4, 2026, indicated if a treatment was not completed as prescribed, documentation would include the reason why it was not completed and any follow up procedures that were provided. No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	42941	A. BUILDING: _____ B. WING _____	09/29/2026

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01970	Continued From page 43	01970		
01970 SS=F	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure that up-to-date written or electronic treatment orders were maintained for one of one resident receiving treatments (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 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: R2 was admitted to licensee on August 31, 2026, and began receiving assisted living services. R2's Addendum to Contract (service plan) dated September 29, 2026, indicated R2's services included assistance with medication administration and blood glucose monitoring three times daily.	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	42941	A. BUILDING: _____ B. WING _____	09/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01970	Continued From page 44 R2's Individualized Treatment or Therapy Management Plan dated August 20, 2026, indicated R2's treatments included blood glucose monitoring, vital signs monitoring, and an American Diabetic Association (ADA) diet. R2's record lacked a written or electronically recorded order from an authorized prescriber for blood glucose monitoring, vital sign monitoring, or a specialized diet. On September 29, 2026, at 11:32 a.m., clinical nurse supervisor (CNS)-B stated R2's record did not include signed physician orders for medications or treatments. CNS-B stated they have reached out to all providers for medication and treatment orders but have not yet received them. The licensee's 7.20 Medication and Treatment Orders policy dated August 4, 2026, indicated the registered nurse would be responsible for assuring that current, authorized prescriber orders for medications or treatments administered by the staff were kept on file in the residents' records. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		

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

Food & Beverage Inspection Report

Establishment Info

Terrace Haven Care
1220 Lincoln Terrance
Columbia Heights, MN
Parcel:

Phone:

License Info

License: HFID 42941

Risk:
License:
Expires on:
CFPM: Leslie Huna
CFPM #: 14759; Exp: 12/22/2027

Inspection Info

Report Number: F1063261286
Inspection Type: Full - Single
Date: 9/28/2026 Time: 1:00 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 1
Total Priority 2 Orders: 1
Total Priority 3 Orders: 1
Delivery:

! **New Order: 3-300B Protection from Contamination: cross-contamination, eggs**
3-302.11A(1) *Priority Level: Priority 1 CFP#: 15*
MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.
COMMENT: UNPASTEURIZED RAW SHELL EGGS WERE STORED OVER READY TO EAT PRODUCE IN THE FRIDGE. DISCUSSED FOOD STORAGE WITH STAFF. GUIDANCE SENT WITH REPORT.
Comply By: 9/28/2026 Originally Issued On: 9/28/2026

New Order: 4-200 Equipment Design and Construction
4-204.112A *Priority Level: Priority 3 CFP#: 36*
MN Rule 4626.0620A Provide a temperature measuring device located in the warmest part of mechanically refrigerated units and coolest part of hot food storage units that are capable of measuring air temperature or a simulated product temperature.
COMMENT: NO AMBIENT THERMOMETER IN FRIDGE. DISCUSSED THE ABOVE REQUIREMENT WITH STAFF.
Comply By: 9/28/2026 Originally Issued On: 9/28/2026

New Order: 4-300 Equipment Numbers and Capacities
4-302.12B *Priority Level: Priority 2 CFP#: 36*
MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.
COMMENT: ESTABLISHMENT DID NOT HAVE A FOOD THERMOMETER AVAILABLE ONSITE. COMPLY WITH RULE ABOVE.
Comply By: 10/5/2026 Originally Issued On: 9/28/2026

Food & Beverage General Comment

Inspection was completed with MDH Michelle Winters as the lead Health Regulation Division Nurse Evaluator completing the site survey.

Discussed highly susceptible populations, glove use, same day food service, food storage & temperature control, sanitizers, test kits, ware washing, pest control, vomit cleanup procedures, and employee illness policy. CFPM uses certificate at second assisted living location in Coon Rapids.

REFRIGERATOR TEMPERATURE: YOGURT 41 DEGREES F

DISH MACHINE UTENSIL SURFACE TEMPERATURE: <160 DEGREES F

The facility has a residential kitchen. Food must be prepared for same day service only. The kitchen has paneled flooring, tile backsplash, smooth painted walls & ceiling, smooth countertops, and wooden cabinetry. All found to be in good condition.

Equipment includes a two-basin sink with one basin designated for handwashing, and ANSI residential fridge/freezer & dish machine.

Contact Health Regulation Division for plan review approval when facility/kitchen undergoes remodeling, major equipment additions, or changes of equipment due to a menu change.

If any customer complains of illness, establishment is required to notify the Minnesota Department of Health and provide the foodborne illness hotline phone number to the customer: 1-877-366-3455

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 F1063261286 from 9/28/2026

Leslie Huna
Kitchen Manager

Laura Yang,
Public Health Sanitarian 1
651-201-3581
laura.yang@state.mn.us

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL42941001-0	**Date:** September 28, 2026
Facility Name: Terrace Haven Care LLC	
Facility Address: 1220 Lincoln Terrace, Columbia Heights, MN 55421	

☒ **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. Extension cords and flexible cords shall not be a substitute for permanent wiring. [Minn. Stat. 144G.45 subd. 2; MSFC 604.5]

   Comments: Extension cords were used in resident bedrooms one, four, and five, to supply power to personal electronics.

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 occupied resident bedrooms four and five, the egress windows were obstructed by the storage of personal belongings in front of the windows.

☒ **TAG IDENTIFICATION: 0810**

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

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

   Comments: The fire safety and evacuation plan (FSEP) was stored in a lockable cabinet in the sunroom. The FSEP was not readily available in the event of an emergency to all building occupants and emergency responders.

2. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include the location and number of resident rooms. [Minn. Stat. 144G.45 subd.2]

   Comments: The emergency evacuation floor plans displayed in the building identified five resident bedrooms. Numbers were not posted at the resident room doors. Resident room numbers need to be installed at the doors and correspond with the evacuation floor plans 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 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 site specific employee actions to take in the event of a fire or similar emergency relative to the assisted living building layout and environmental risks.
   - The employee procedures were from third party templates.
   - Employees were inaccurately directed to use pull fire alarms.
   - Employees were inaccurately directed to a fire extinguisher installed in the family room.

4. 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. The instructions were from a third party template. Additionally, there were no written procedures for use of emergency escape and rescue openings (egress windows) in resident bedrooms.

5. 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 fire safety and evacuation plan provided by the licensee failed to include evacuation procedures for the individualized unique needs of residents.