



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

February 17, 2026

Licensee

Twincities Loyal Holistic Care LLC

860 Rogers Court

Eagan, MN 55123

RE: Project Number(s) SL38188016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 21, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility.**

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

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

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

If you have any questions, please contact me.

Sincerely,



Jodi Johnson, Supervisor

State Evaluation Team

Email: Jodi.Johnson@state.mn.us

Telephone: 507-344-2730 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38188	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/21/2026
NAME OF PROVIDER OR SUPPLIER TWINCITIES LOYAL HOLISTIC CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 860 ROGERS COURT EAGAN, MN 55123		
(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: SL38188016-0 On January 20, 2026, through January 21, 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 two residents; two receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 420 SS=F	144G.40 Subdivision 1 Responsibility for housing and services	0 420			

Minnesota Department of Health

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

TITLE

(X6) DATE

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0 420	Continued From page 1 The facility is directly responsible to the resident for all housing and service-related matters provided, irrespective of a management contract. Housing and service-related matters include but are not limited to the handling of complaints, the provision of notices, and the initiation of any adverse action against the resident involving housing or services provided by the facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide sufficient management, control, and operation of the housing and services provided by the facility. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: The licensee had an assisted living license, effective February 14, 2025. The licensee's (renewal) "Application for Assisted Living License", section titled "Official Verification of Owner or Authorized Agent", (page four and five of the application), identified an affirmative checkmark next to the statement, "I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659, governing the	0 420			

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0 420	Continued From page 2 provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract." Another checkmark was noted at the statement, "I have examined this application and all attachments, and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct and complete. I will notify MDH, in writing, of any changes to this information as required." Page six was electronically signed by the owner agent on December 5, 2024. As a result of this survey, the following orders were issued under 0480, 0550, 0630, 0640, 0660, 0680, 0775, 0800, 0810, 0950, 1320, 1330, 1440, 1640, 1650, 1700, 1730, 1750, 1790, 1820, 1880, 1890, 1940, 1970 , which indicated the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.01 to 144G.95. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 420			
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the	0 480			

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0 480	Continued From page 3 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 allowed provided the facility keeps them clean and in good condition;	0 480			

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0 480	Continued From page 4 (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) 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 the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated January 20, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			

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0 550	Continued From page 5	0 550			
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post in a conspicuous place, information about the licensee's grievance procedure with the required content. This had the potential to affect the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or 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).	0 550			

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0 550	Continued From page 6 The findings include: On January 20, 2026, at 9:46 a.m. during the facility tour, the surveyor did not observe any signage or information posted regarding the grievance procedure, and the name, telephone number and email contact information for individuals who were responsible for handling resident grievances. On January 21, 2026, at 8:47 a.m., licensed assisted living director (LALD)-A stated the grievance procedure used to be posted on the bulletin board near the kitchen and did not know why it was no longer posted. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550			
0 630 SS=E	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	0 630			

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0 630	Continued From page 7 by: Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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 was admitted on March 1, 2024, with diagnoses that included diabetes. On January 21, 2026, at 7:02 a.m., the surveyor observed unlicensed personnel (ULP)-C administer medications to R1. R1's Support Plan (also used as the service plan) dated August 1, 2025, indicated R1 received services to include medication administration, medication setups and monitoring, and mental health management. R1's IAPP dated December 2, 2025, identified the following areas of vulnerability: -Alcohol use and/or history of use including the resident's alcohol use not prescribed: Yes, specify: drinks alcohol at friends house per client (resident) -Drug use and/or history of use, including the	0 630			

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0 630	Continued From page 8 resident's drug use not prescribed: Yes, specify: his room smells marijuana -Behavior- Agitation: agitation triggered by alcohol conceptions -Behavior-Physical aggression: under the influence, the client threatens staff that he will hit them, No history within last 90 days -Behavior-Property destruction: under alcohol influence, no history within last 90 days -Behavior-Socially inappropriate: threatens the staff -Behavior- Verbal aggression: he gets loud -Mental Illness-major depressive disorder -Mental Illness-Hallucinations: hallucination noted under influence of alcohol R1's IAPP did not include the following required items: -the resident's susceptibility to abuse by another individual, including other vulnerable adults -statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults -specific interventions for the identified vulnerabilities as required On January 21, 2026, at 9:23 a.m., clinical nurse supervisor (CNS)-B reviewed R1's IAPP and stated R1's IAPP did not include the required content as noted above. The licensee's Vulnerable Adult policy dated November 13, 2025, indicated an individual abuse prevention plan shall be established for each vulnerable adult for whom assisted living services are provided. The plan shall contain an individualized assessment of the resident's susceptibility to abuse by another individual, including other vulnerable adults. The plan shall contain the residents' risk of abusing other	0 630			

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0 630	Continued From page 9 vulnerable adults. The plan shall contain statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. The plan will be implemented immediately and evaluated at each supervisory visit or more frequently, if necessary. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to support protection and safety by not posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) as required. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a	0 640			

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0 640	Continued From page 10 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: The licensee failed to post information and the reporting number for MAARC to report suspected maltreatment of a vulnerable adult under section 626.557. On January 20, 2026, at 9:15 a.m., the surveyor observed the entry and common areas within the facility and noted there was no posting of the information and reporting number for MAARC, as required. On January 20, 2026, at 8:47 a.m., licensed assisted living director (LALD)-A stated the MAARC information used to be posted on the bulletin board near the kitchen and did not know why it was no longer posted. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640			
0 660 SS=D	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	0 660			

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0 660	Continued From page 11 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 maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) by failing to complete a two-step TST (tuberculin skin test) or other evidence of tuberculosis (TB) screening such as a blood test for two of two employees (unlicensed personnel (ULP)-C and ULP-D). 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: ULP-C ULP-C was hired on September 1, 2023, to	0 660			

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0 660	Continued From page 12 provide direct care and services to the facility's residents. ULP-C's employee record contained a Consent and Release for TB Screening document dated September 1, 2023. The document indicated the following: -On September 1, 2023, at 11:30 a.m., the registered nurse (RN) administered the first step TST to ULP-C's right arm -On September 2, 2023, at 2:00 p.m., the RN documented a negative TST result -On September 3, 2023, at 2:30 p.m., the RN documented a negative TST result ULP-D ULP-D was hired on June 15, 2023, to provide direct care and services to the facility's residents. ULP-D's employee record contained a Consent and Release for TB Screening document dated June 12, 2023. The document indicated the following: -On June 12, 2023, at 11:00 a.m., the RN administered the first step TST to ULP-D's left arm. -On June 12, 2023, at 12:00 p.m., the RN documented a negative TST result -On June 13, 2023, at 11:00 a.m., the RN documented a negative TST result The RN did not wait 48-72 hours after the TST was administered to read ULP-C and ULP-D's TST results. The RN documented a second negative TST result for both ULP-C and ULP-D; however, it was based on the administration of the first step TST. The RN did not administer a second step TST within one to three weeks after the administration of the first TST.	0 660			

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NAME OF PROVIDER OR SUPPLIER TWINCITIES LOYAL HOLISTIC CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 860 ROGERS COURT EAGAN, MN 55123		
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0 660	Continued From page 13 On January 21, 2026, at 9:35 a.m., licensed assisted living director (LALD)-A reviewed ULP-C and ULP-D's Consent and Release for TB Screening documents. LALD-A stated he believed the document indicated both ULP-C and ULP-D did complete a two step TST because the RN documented two negative results. Clinical nurse supervisor (CNS)-B stated she was not employed with the licensee at the time of ULP-C and ULP-D were hired and could not speak on the testing process at that time. The licensee's Tuberculosis Screening/Prevention policy dated November 13, 2025, indicated the following: -employees receive baseline TB screening upon hire -the baseline test may be either TST (2-step) or BAMT -If the first-step TST is negative, the second-step TST will be administered 1-3 weeks after the first TST result was read. 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;	0 680			

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0 680	Continued From page 14 (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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all residents, staff, and visitors of the facility. 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 2025 Emergency Preparedness and Fire Safety and Evacuation Manual was	0 680			

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0 680	Continued From page 15 reviewed and lacked the following: - arrangement with other faculties On January 21, 2026, at 10:17 a.m., licensed assisted living director (LALD)-A stated he had a verbal arrangement with two facilities near the licensee; however, could not provide documentation of the mutual aid memorandum of understanding for those facilities. The licensee's Emergency Preparedness policy dated November 13, 2025, indicated the licensee would have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 775 SS=I	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level three violation (a violation that harmed a resident's health or safety,	0 775			

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0 775	Continued From page 16 or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated January 20, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775			
0 800 SS=A	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G.	0 800			

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0 800	Continued From page 17 This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated January 20, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans	0 810			

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0 810	Continued From page 18 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, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated	0 810			

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0 810	Continued From page 19 Janaury 20, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	0 810			
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative.	0 950			

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0 950	Continued From page 20 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensee provided the required notice for right to a designated representative with the required verbiage on a document separate from the contract for one of one resident (R1). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) 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 the residents). The findings include: R1 was admitted on March 1, 2024, with diagnoses that included diabetes. R1's undated, Assisted Living Contract for Housing and Services included a column labeled "Designated Agent of Resident" which "N/A" was documented in. R1's record lacked evidence in writing of providing on a document separate from the contact verbatim notice of "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not	0 950			

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0 950	Continued From page 21 take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." On January 21, 2026, at 8:43 a.m., licensed assisted living director (LALD)-A stated R1 declined to designate a representative which is why "N/A" was documented in the Designated Agent of Resident column. LALD-A stated he thought this met the requirements for designation of representatives. On January 21, 2026, at 8:43 a.m., LALD-A provided a blank Designation of Representative document that included the required content that he located in the licensee's document binder. LALD-A stated the licensee had not utilized this form yet for either of the two residents but have both residents fill it out and use it going forward with any new resident admissions. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950			
01320 SS=D	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	01320			

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01320	Continued From page 22 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: Based on observation, interview, and record review, the licensee failed to ensure training and competency was completed for two of two unlicensed personnel (ULP-C and ULP-D) to include all required content. 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: ULP-C ULP-C was hired on September 1, 2023, to provide direct care and services to the facility's residents. On January 20, 2026, at 10:56 a.m., the surveyor observed ULP-C administer medications to R2. ULP-C's employee record lacked evidence of training for the following topics:	01320			

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01320	Continued From page 23 -documentation requirements for all services provided -reports of changes in the resident's condition to the supervisor designated by the facility; -maintenance of a clean and safe environment; -appropriate and safe techniques in personal hygiene and grooming including: -hair care and bathing -care of teeth, gums, and oral prosthetic devices -care and use of hearing aids -dressing and assisting with toileting -standby assistance techniques and how to perform them; -basic nutrition, meal preparation, food safety, and assistance with eating; -preparation of modified diets as ordered by a licensed health professional; -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 -understanding appropriate boundaries between staff and residents and the resident's family; ULP-C's employee record lacked evidence of competency evaluation for the following topics: -appropriate and safe techniques in personal hygiene and grooming including: -hair care and bathing -care of teeth, gums, and oral prosthetic devices -care and use of hearing aids -dressing and assisting with toileting -standby assistance techniques and how to perform them ULP-D ULP-D was hired on June 15, 2023, to provide direct care and services to the facility's residents.	01320			

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01320	Continued From page 24 ULP-D's employee record lacked evidence of training for the following topics: -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. ULP-D's employee record lacked evidence of competency evaluation for the following topics: -appropriate and safe techniques in personal hygiene and grooming including: -hair care and bathing -care of teeth, gums, and oral prosthetic devices -care and use of hearing aids -dressing and assistance with toileting -standby assistance techniques and how to perform them On January 21, 2026, at 8:53 a.m., licensed assisted living director (LALD)-A reviewed ULP-C and ULP-D's training transcript together. LALD-A stated ULP-C and ULP-D's record lacked documentation of the above training and competency evaluations. LALD-A stated he was unsure of why ULP-C and ULP-D did not complete the above training and stated it must have been missed. LALD-A stated all ULP were competency tested on all required topics by the registered nurse (RN); however, they may not have documented all areas individually. The licensee's Staff Competency policy dated November 13, 2025, indicated training and competency evaluation for all ULPs would include: a. documentation requirements for all services provided b. reports of changes in the resident's condition to	01320			

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01320	Continued From page 25 the supervisor c. basic infection control, including blood-borne pathogens d. maintenance of clean and safe environment e. appropriate and safe techniques in person hygiene and grooming including: -hair care and bathing -care of teeth, gums, and oral prosthetic devices -care and use of hearing aids -dressing and assisting with toileting f. training on the prevention of falls for providers working with the elderly or individuals at risk of falls g. standby assistance techniques and how to perform them h. medication, exercise techniques and how to perform them i. basic nutrition, meal preparation, of modified diets as ordered by a licensed health professional, food safety and assistance with eating j. 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 k. awareness of confidentiality and privacy l. understanding appropriate boundaries between staff and residents and the resident's family m. procedures to utilize in handling various emergency situations n. awareness of commonly used health technology equipment and assistive devices No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01320			

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01330	Continued From page 26	01330			
01330 SS=D	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 observation, interview, and record review, the licensee failed to ensure training and competency was completed for two of two unlicensed personnel (ULP-C and ULP-D) to include all required content. 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).	01330			

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NAME OF PROVIDER OR SUPPLIER TWINCITIES LOYAL HOLISTIC CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 860 ROGERS COURT EAGAN, MN 55123			
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01330	Continued From page 27 The findings include: ULP-C ULP-C was hired on September 1, 2023, to provide direct care and services to the facility's residents. On January 20, 2026, at 10:56 a.m., the surveyor observed ULP-C administer medications to R2. ULP-C's employee record lacked evidence of training for the following topics: -observing, reporting, and documenting of resident status; -safe transfer techniques and ambulation; -range of motion and positioning ULP-C's employee record lacked evidence of competency evaluation for the following topics: -safe transfer techniques and ambulation; -range of motion and positioning ULP-D ULP-D was hired on June 15, 2023, to provide direct care and services to the facility's residents. ULP-D's employee record lacked evidence of competency evaluation for the following topics: -safe transfer techniques and ambulation; -range of motion and positioning On January 21, 2026, at 8:53 a.m., licensed assisted living director (LALD)-A reviewed ULP-C and ULP-D's training transcript together. LALD-A stated ULP-C and ULP-D's record lacked documentation of the above training and competency evaluations. LALD-A stated he was unsure of why ULP-C and ULP-D did not complete the above training and stated it must have been missed. LALD-A stated all ULP were	01330			

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01330	Continued From page 28 competency tested on all required topics by the registered nurse (RN); however, they may not have documented all areas individually. The licensee's Staff Competency policy dated November 13, 2025, indicated training and competency evaluation for all ULPs would include: -observation, reporting, and documenting of resident status -safe transfer techniques and ambulation -range of motion and positioning No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01330			
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the	01440			

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01440	Continued From page 29 individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual begins working for the licensee for two of two unlicensed personnel (ULP-C and ULP-D). 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: ULP-C ULP-C was hired on September 1, 2023, to provide direct care and services to the facility's residents. On January 20, 2026, at 10:56 a.m., the surveyor observed ULP-C administer medications to R2. ULP-C's employee record lacked documentation of a RN supervision ULP-C performing delegated tasks within 30 days of beginning work with the licensee.	01440			

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01440	Continued From page 30 ULP-D ULP-D was hired on June 15, 2023, to provide direct care and services to the facility's residents. ULP-D's employee record lacked documentation of a RN supervision ULP-C performing delegated tasks within 30 days of beginning work with the licensee. On January 21, 2026, at 8:56 a.m., licensed assisted living director (LALD)-A stated the licensee did not complete an RN supervision for ULP performing delegated tasks within 30 days of beginning work with the licensee. LALD-A stated he was aware of this requirement in Home Care but was not aware that it was also required in Assisted Living. The licensee's Supervision: Unlicensed Staff policy dated November 13, 2025, indicated direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the licensee and first performs the delegated tasks for residents and thereafter as needed based on performance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440			
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.	01640			

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01640	Continued From page 31 (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 the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a written service plan was signed and revised to reflect the current services provided for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	01640			

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01640	Continued From page 32 R1 was admitted on March 1, 2024, with diagnoses that included diabetes. On January 21, 2026, at 7:02 a.m., the surveyor observed unlicensed personnel (ULP)-C administer medications to R1. R1's Service Recap Summary dated January 2026, indicated R1 received the following services: -daily blood pressure checks -twice daily blood glucose checks -bathing reminders every two days -weekly nail care -ambulation -safety checks R1's Support Plan (also used as the service plan) dated August 1, 2025, indicated R1 received services to include medication administration, medication setups and monitoring, and mental health management. R1's support plan did not include the following services: -daily blood pressure checks -twice daily blood glucose checks -bathing reminders every two days -weekly nail care -ambulation -safety checks R1's support plan was not signed by R1 or the licensee. On January 21, 2026, at 7:48 a.m., clinical nurse supervisor (CNS)-B stated R1's support plan did not include all services R1 received from the licensee and was not signed by R1 or the licensee.	01640			

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01640	Continued From page 33 The licensee's Service Plan policy dated November 13, 2025, indicated the initial service plan and any revisions are signed by a representative from the licensee and the resident or resident's representative, indicating agreement with the services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and	01650			

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01650	Continued From page 34 (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included all required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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: R1 was admitted on March 1, 2024, with diagnoses that included diabetes. R1's Support Plan (also used as the service plan) dated August 1, 2025, indicated R1 received services to include medication administration, medication setups and monitoring, and mental health management. R1's service plan lacked the following content: - the schedule and methods of monitoring assessments of the resident; - the schedule and methods of monitoring staff providing services; and - contingency plan that includes: - the action to be taken if the scheduled service	01650			

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01650	Continued From page 35 cannot be provided; - information and method to contact the facility: - the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency and - the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters On January 21, 2026, at 7:48 a.m., clinical nurse supervisor (CNS)-B stated the licensee created resident service plans through the electronic health record (EHR) but could not locate a service plan in R1's record. Licensed assisted living director (LALD)-A stated the licensee used the residents' department of human services (DHS) support plan as the service plan. LALD-A and CNS-B reviewed the support plan and stated it did not include the required content as noted above. The licensee's Service Plan policy dated November 13, 2025, indicated an individualized service plan was implemented for all residents. The service plan includes the following: -a description of the services to be provided; the service description may be in the form of the resident's care plan developed with the resident/responsible party -the fees for services and the frequency of each service, according to the residents' current review or assessment and resident preferences -the identification of the staff or categories of staff who will provide the services	01650			

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01650	Continued From page 36 -the schedule and methods of monitoring reviews or assessments of the residents -the schedule and method of monitoring staff providing services -a contingency plan that includes the following: -action to be taken if the scheduled service cannot be provided -information and method for a resident or resident's representative to contact the facility -names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition -the identification of and information as to who has the authority to sign for the resident in an emergency -circumstances in which emergency medical services are not to be summoned and declarations made by the residents related to health care directives No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650			
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	01700			

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01700	Continued From page 37 an identification and review of all medications the 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 observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management assessment which included the required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	01700			

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01700	Continued From page 38 R1 was admitted on March 1, 2024, with diagnoses that included diabetes. On January 21, 2026, at 7:02 a.m., the surveyor observed unlicensed personnel (ULP)-C administer medications to R1. R1's Support Plan (also used as the service plan) dated August 1, 2025, indicated R1 received services to include medication administration. R1's medication administration record (MAR) dated January 2026, included the following medications: -allopurinol 300 milligrams (mg); take one tablet by mouth daily (gout) -amlodipine 10 mg; take one tablet by mouth daily (blood pressure) -fluticasone propionate 50 micrograms (mcg); use one spray in each nostril daily (allergies) -Jardiance 10 mg; take one tablet by mouth once daily (blood thinner) -Losartan 100 mg; take one tablet by mouth daily (blood pressure) -Metformin 500 mg; take four tablets by mouth once daily (diabetes) -metoprolol succinate 100 mg; take one and one-half tablet by mouth daily (blood pressure) -naltrexone 50 mg; take one tablet by mouth daily (opioid use disorder) -omeprazole 20 mg; take one capsule by mouth twice daily (reflux) -tamsulosin 0.4 mg; take one capsule by mouth daily (prostate) -atorvastatin 40 mg; take one tablet by mouth at bedtime (cholesterol) -mirtazapine 30 mg; take one tablet by mouth daily at bedtime (anxiety/depression) -acetaminophen 500 mg; take two capsules by mouth three times a day as needed for muscle	01700			

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01700	Continued From page 39 pain -albuterol inhaler; inhale two puffs every four hours as needed (asthma), self-admin -calcium carbonate 500 mg; chew and swallow one tablet four times daily as needed (reflux) -cetirizine take one tablet by mouth daily as needed (allergies) -ibuprofen 600 mg; take by mouth three times per day as needed (pain) -loperamide 2 mg; take 2 mg by mouth after each loose stool, maximum 16 mg/day -cyclobenzaprine 5 mg; take one tablet by mouth at bedtime as needed for shoulder spasms -nicotine 2 mg gum; take one every hour as needed for nicotine craving -Zofran 4 mg; administer 4 mg every eight hours to dissolve under tongue (nausea) R1's record lacked evidence the RN conducted a face-to-face review of all medications R1 was known to be taking to include indications for use, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. In addition, R1's record did not identify interventions needed in the management of medications to prevent diversion of medications by the resident or others who may have access to the medications. On January 21, 2026, at 7:54 a.m., licensed assisted living director (LALD)-A stated a nurse who no longer worked for the licensee would have been the one to document the medication management assessment if it was completed. Clinical nurse supervisor (CNS)-B reviewed R1's paper chart and electronic record and could not locate a face-to-face medication management assessment to include the required content. The licensee's Assessment of Medications policy	01700			

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01700	Continued From page 40 dated November 13, 2025, indicated the RN will provide and document a face-to-face assessment with the resident. The assessment includes the following elements: -identification of all medications, including over-the-counter and herbal/dietary supplements -medication reconciliation -identification of the most accurate list of all medications the resident is taking, including the name, dosage, frequency and route by comparing the resident record to an external list of medications obtained from the resident, hospital, prescriber or other provider -assessment of the following: indication for medications, effectiveness of drug therapy, side effects, immediate desired effects, unusual and unexpected effects, actual or potential drug interactions, duplicate drug therapy, non-adherence with drug therapy, drug therapy currently associated with laboratory monitoring, allergic reactions, changes in condition that contraindicate continued administration of the medication , any difficulties with taking the medication and resident preferences in how to take medications -interventions needed in management of medications to prevent the potential for diversion of medications by the resident or others with access to it. The resident and resident's legal or designated representatives will be educated regarding interventions to management the medications and prevent diversion. -medication reassessment will occur at the following times: resident symptomology, problems or concerns that may be medication-related, with a new prescription, OTC or herbal products and annually No further information was provided.	01700			

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01700	Continued From page 41	01700			
	TIME PERIOD FOR CORRECTION: Seven (7) days				
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use	01730			

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01730	Continued From page 42 to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized medication management plan with the required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted on March 1, 2024, with diagnoses that included diabetes. On January 21, 2026, at 7:02 a.m., the surveyor observed unlicensed personnel (ULP)-C administer medications to R1. R1's Support Plan (also used as the service plan) dated August 1, 2025, indicated R1 received services to include medication administration,	01730			

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01730	Continued From page 43 medication setups and monitoring, and mental health management. R1's medication administration record (MAR) dated January 2026, included the following medications: -allopurinol 300 milligrams (mg); take one tablet by mouth daily (gout) -amlodipine 10 mg; take one tablet by mouth daily (blood pressure) -fluticasone propionate 50 micrograms (mcg); use one spray in each nostril daily (allergies) -Jardiance 10 mg; take one tablet by mouth once daily (blood thinner) -Losartan 100 mg; take one tablet by mouth daily (blood pressure) -Metformin 500 mg; take four tablets by mouth once daily (diabetes) -metoprolol succinate 100 mg; take one and one-half tablet by mouth daily (blood pressure) -naltrexone 50 mg; take one tablet by mouth daily (opioid use disorder) -omeprazole 20 mg; take one capsule by mouth twice daily (reflux) -tamsulosin 0.4 mg; take one capsule by mouth daily (prostate) -atorvastatin 40 mg; take one tablet by mouth at bedtime (cholesterol) -mirtazapine 30 mg; take one tablet by mouth daily at bedtime (anxiety/depression) -acetaminophen 500 mg; take two capsules by mouth three times a day as needed for muscle pain -albuterol inhaler; inhale two puffs every four hours as needed (asthma), self-admin -calcium carbonate 500 mg; chew and swallow one tablet four times daily as needed (reflux) -cetirizine take one tablet by mouth daily as needed (allergies) -ibuprofen 600 mg; take by mouth three times per	01730			

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01730	Continued From page 44 day as needed (pain) -loperamide 2 mg; take 2 mg by mouth after each loose stool, maximum 16 mg/day -cyclobenzaprine 5 mg; take one tablet by mouth at bedtime as needed for shoulder spasms -nicotine 2 mg gum; take one every hour as needed for nicotine craving -Zofran 4 mg; administer 4 mg every eight hours to dissolve under tongue (nausea) R1's Individualized Medication Management Plan dated December 1, 2025, indicated R1 needed medication management and setup. R1's record lacked an Individualized Medication Management Plan to include the following required content: - a statement describing the medication management services that will be provided; - a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; - documentation of specific resident instructions relating to the administration of medications; - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; - identification of medication management tasks that may be delegated to unlicensed personnel; and - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and - any resident-specific requirements relating to documenting medication administration verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse	01730			

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01730	Continued From page 45 reactions. On January 21, 2026, at 7:57 a.m., clinical nurse supervisor (CNS)-B reviewed R1's medication management plan and stated R1's record lacked the required content as noted above. CNS-B stated the electronic health record system was new to her and she did not realize she had not included the required content in R1's medication plan. The licensee's Service Plan for Medication Management policy dated November 13, 2025, indicated the written medication management plan includes the following provisions: a. a statement describing the medication management services to be provided b. a description of the storage of medications based on the resident assessment and addressing resident preference, risk of diversion, instructions per manufacturer c. documentation procedures d. procedures for medication reconciliation e. identification of person(s) responsible for monitoring medication supplies and ensuring refills are ordered/timely f. description of medication management tasks to be delegated to unlicensed personnel g. plans for staff notifying the licensed health professional when/if a problem with medication management services arise h. any resident-specific requirements related to documenting medication administration, verification that all medications are administered as prescribed and monitoring of medication use to prevent possible complications or adverse reactions No further information was provided.	01730			

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01730	Continued From page 46	01730			
	TIME PERIOD FOR CORRECTION: Seven (7) days				
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse documented resident-specific instructions for one of two residents (R2) whose medication administration was delegated to unlicensed personnel (ULP). 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).	01750			

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01750	Continued From page 47 The findings include: R2 was admitted on April 10, 2023, with diagnoses that included diabetes. R2's Support plan (also used as service plan) dated October 1, 2025, indicated R2 received services to include medication monitoring. LOW BLOOD SUGAR R2's medication administration record (MAR) dated January 2026, included the following as needed (PRN) medications: -Glucose tablets; take four tablets by mouth every hour as needed for low blood sugar -Glucagon; inject 1 milligram (mg) subcutaneously as needed for low blood sugar R2's signed prescriber orders dated May 9, 2025, included the following medications: -Dextrose (glucose) 4 grams; take four tablets by mouth every hour as needed for low blood sugar -Glucagon: 1 mg/0.2 milliliter (ml); inject 1 mg subcutaneous as needed for low blood sugar R2's record did not include instructions regarding what blood sugar result was considered a low blood sugar to indicate administering PRN glucose or Glucagon. In addition, there was no indication when to give the oral glucose verses the injectable Glucagon when R2's blood sugar was low. On January 20, 2026, at 10:56 a.m., the surveyor observed ULP-C supervise R2 check his blood sugar. R2's blood sugar was 69. ULP-C told R2 that she would administer his as needed (PRN) glucose tablets due to his low blood sugar of 69. ULP-C removed four glucose tablets from R2's medication bin. R2 asked ULP-C if he had to take	01750			

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01750	Continued From page 48 all four tablets. At this time, clinical nurse supervisor (CNS)-B stated the order indicated to give four tablets; however, if R2 only wanted to take two, that was his choice. R2 took two of the glucose tablets. The surveyor inquired what blood sugar result was considered low enough to administer the PRN glucose tablets. ULP-C stated she would administer the PRN glucose tablets if R2's blood sugar was 70 or below. CNS-B reviewed R2's prescriber orders for the glucose tablets and Glucagon and stated it did not include what blood sugar result was considered a low blood sugar. ACETAMINOPHEN R2's MAR dated January 2026, included the following: -acetaminophen 500 mg; take 1-2 tablets every six hours as needed for pain, order dated May 9, 2025 The licensee failed to have resident-specific instructions regarding when to give one or two tablets of acetaminophen. On January 21, 2026, at 8:55 a.m., CNS-B stated R1's record did not include resident specific instructions on when to administer one tablet versus two tablets of acetaminophen for pain. The licensee's Medication Administration policy dated November 13, 2025, indicated all staff with responsibility for medication administration have access to information about the medication being administered, including but not limited to: a. Purpose b. Dosage c. Route d. Frequency e. Instructions related to the medication and	01750			

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01750	Continued From page 49 specific to the residents, as appropriate f. Side effects g. Resident allergies to mediations No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750			
01790 SS=D	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must	01790			

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01790	Continued From page 50 address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) developed training and competencies for two of two unlicensed personnel (ULP-C and ULP-D) providing medications to residents for unplanned time away from home when the licensed nurse was not available.	01790			

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01790	Continued From page 51 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: ULP-C ULP-C was hired on September 1, 2023, to provide direct care and services to the facility's residents. ULP-C's employee record lacked documentation of training and competencies for unplanned time away when the RN was not available. ULP-D ULP-D was hired on June 15, 2023, to provide direct care and services to the facility's residents. ULP-D's employee record lacked documentation of training and competencies for unplanned time away when the RN was not available. On January 21, 2026, at 9:15 a.m., licensed assisted living director (LALD)-A stated all ULP may provide medications to residents for unplanned time away and were trained and competency tested, but could not locate the documentation of the training or competencies for ULP-C and ULP-D. The licensee's Medication Management Plan for Residents Away from Home policy dated	01790			

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01790	Continued From page 52 November 13, 2025, indicated for unplanned times away from home for temporary periods when an adequate medication supply cannot be obtained from the pharmacy or set up by the RN in a timely manner, the RN may delegate to an ULP to provide the medications based on the following: -the RN has trained the ULP and determined the ULP competency to follow procedures for giving medications to residents. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790			
01820 SS=D	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 observation, interview, and record review, the licensee failed to ensure current written or electronically recorded prescriptions were obtained for all medications the provider managed for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or	01820			

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01820	Continued From page 53 a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 was admitted on March 1, 2024, with diagnoses that included diabetes. On January 21, 2026, at 7:02 a.m., the surveyor observed unlicensed personnel (ULP)-C administer medications to R1. R1's Support Plan (also used as the service plan) dated August 1, 2025, indicated R1 received services to include medication administration. R1's medication administration record (MAR) dated January 2026, included the following medications: -mirtazapine 30 milligrams (mg); take one tablet by mouth at bedtime (depression) -Zofran 4 mg; administer 4 mg every eight hours to dissolve under tongue (nausea/vomiting) R1's record lacked signed prescriber orders for mirtazapine and Zofran. On January 21, 2026, at 8:07 a.m., clinical nurse supervisor (CNS)-B stated the licensee used R1's After Visit Summary (AVS) for prescriber orders and would provide the AVS to the surveyor. On January 21, 2026, at 8:14 a.m., CNS-B provided R1's AVS with a medication list dated January 5, 2026. CNS-B and the surveyor reviewed the AVS and medication list together. The medication list did not include Zofran. The medication list included mirtazapine 30 mg; take one tablet by mouth at bedtime. However, the AVS was not signed by R1's prescriber.	01820			

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01820	Continued From page 54 The licensee's Prescriber's Order policy dated November 13, 2025, indicated written orders from an authorized prescriber will be obtained for all medications and treatments with which the assisted living facility assists residents, including over the counter medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820			
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the medication refrigerator maintained an acceptable temperature to ensure the medications were stored according to manufacturer's recommendations in the licensee's only medication refrigerator. 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	01880			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER TWINCITIES LOYAL HOLISTIC CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 860 ROGERS COURT EAGAN, MN 55123		
(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
01880	Continued From page 55 has affected or has the potential to affect a large portion or all of the residents). The findings include: On January 20, 2026, at 9:30 a.m. during the entrance conference, clinical nurse supervisor (CNS)-B stated medications requiring refrigeration were stored in the mini refrigerator located in the kitchen. On January 21, 2026, at 8:05 a.m., the surveyor observed a mini refrigerator with a lock on it located in the kitchen. The surveyor requested to see the contents of the refrigerator. CNS-B unlocked the mini refrigerator and noted two boxes of R2's insulin and a thermometer. CNS-B was unsure how often the temperature was checked or if it was documented. Licensed assisted living director (LALD)-A stated the staff checked the temperature of the refrigerator every day; however, the licensee did not document it. The licensee's Storage/Control of Medications policy dated November 13, 2025, indicated medications requiring refrigeration are clearly labeled and stored in an enclosed container or area separated from foods. Temperature is maintained at 35-40 degrees. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in	01890			

Minnesota Department of Health

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01890	Continued From page 56 the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure insulin pens had a pharmacy label for the licensee's only resident with insulin (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 the potential to affect a large portion or all of the residents). The findings include: R2 was admitted on April 10, 2023, with diagnoses that included diabetes. R2's Support plan (also used as the service plan) dated October 1, 2025, indicated R2 received services to include medication monitoring. R2's medication administration record (MAR) dated January 2026, included the following insulin orders: -Lantus insulin 100 units/milliliter (ml); inject 8 units subcutaneously at bedtime -Insulin Aspart 100 units/ml; inject 8 units as needed for blood sugars between 250-595	01890			

Minnesota Department of Health

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01890	Continued From page 57 On January 20, 2026, at 10:56 a.m., the surveyor observed unlicensed personnel (ULP)-C removed a plastic bin with diabetic supplies and two insulin pens in it. Neither R2's Lantus insulin pen or Insulin Aspart pen had a pharmacy label on them. On January 21, 2026, at 8:03 a.m., clinical nurse supervisor (CNS)-B observed R2's insulin pens and stated they did not have pharmacy labels on them. CNS-B stated the insulin boxes had a pharmacy label on them, but the individual insulin pens did not have labels on them. CNS-B stated the boxes of insulin came in a plastic bag with a pharmacy label and placed the insulin pens in the plastic bag that were in use for R2. CNS-B stated she would contact the pharmacy and request each individual insulin pen had a pharmacy label on them going forward. The licensee's Storage/Control of Medications policy dated November 13, 2025, indicated the medication is labeled completely and legibly. The medication label should contain the following: -prescription number and name of medication -strength and quantity -expiration date for time-dated drugs -directions for use -resident's name -prescriber's name -date issued -name and address of licensed pharmacy issuing the medication No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			

Minnesota Department of Health

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01940	Continued From page 58	01940			
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of one	01940			

Minnesota Department of Health

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01940	Continued From page 59 resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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: R1 was admitted on March 1, 2024, with diagnoses that included diabetes. On January 21, 2026, at 7:02 a.m., the surveyor observed unlicensed personnel (ULP)-C check R1's blood pressure and pulse and provide supervision and verbal cues to R1 for blood sugar checks. R1's Support Plan (also used as the service plan) dated August 1, 2025, indicated R1 received services to include medication administration, medication setups and monitoring, and mental health management. R1's support plan did not include twice daily blood glucose checks and daily blood pressure and pulse checks. R1's medication administration record (MAR) dated January 2026, included the following: -Blood glucose check: check blood sugar twice daily, prescriber order dated May 12, 2025 R1's Service Recap Summary dated January 2026, indicated the following: -Daily blood pressure checks -Twice daily blood glucose checks	01940			

Minnesota Department of Health

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01940	Continued From page 60 R1's record lacked prescriber orders for daily blood pressure and pulse checks. R1's record contained a Treatment and Therapy Plan Assessment dated January 20, 2026, that included the following: -Statement of Medication Management services: Needs medication management and setup. Needs help with medication administration, "client reside in a customized living facility, medications are administered by trained staff in accordance with facility policy and state regulations". -Impaired Functional Mobility: balance problem while walking. Uneven movement, uses a cane -Self Medication Management: can correctly administer inhalant medications? Yes R1's record lacked a treatment management plan to include the following required content: - statement of the type of service that will be provided; - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that will be delegated to unlicensed personnel; - procedures for notifying a registered nurse when a problem arose with treatments or therapy services; and - any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On January 21, 2026, at 7:59 a.m., the surveyor reviewed R1's treatment and therapy assessment plan with clinical nurse supervisor (CNS)-B.	01940			

Minnesota Department of Health

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01940	Continued From page 61 CNS-B stated R1's record lacked a treatment management plan to include the required content as listed above. CNS-B stated the electronic health record system was new to her and she did not realize she had to create a separate treatment plan for residents with treatments. The licensee's Treatment and Therapy Management Plan policy dated November 13, 2025, indicated the RN will prepare an individualized treatment or therapy management plan for each resident receiving ordered or prescribed treatments or therapy services, which addresses: a. Type of service to be provided b. Procedures for documenting treatments or therapies c. Procedures for monitoring treatments or therapies to prevent possible complications or adverse reactions - identification of treatment or therapy task delegated to unlicensed personnel d. Procedures for notifying the RN or licensed health professional when a problem arises related to the treatment or therapy service No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940			
01970 SS=D	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	01970			

Minnesota Department of Health

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01970	Continued From page 62 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 observation, interview, and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for one of one resident (R1) receiving treatments. 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: R1 was admitted on March 1, 2024, with diagnoses that included diabetes. R1's Support Plan (also used as the service plan) dated August 1, 2025, indicated R1 received services to include medication administration, medication setups and monitoring, and mental health management. R1's support plan did not include daily blood pressure and pulse checks. On January 21, 2026, at 7:02 a.m., the surveyor observed unlicensed personnel (ULP)-C check R1's blood pressure and pulse and provide supervision and verbal cues to R1 for blood sugar checks. ULP-C stated the licensee checked R1's	01970			

Minnesota Department of Health

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01970	Continued From page 63 blood pressure and pulse every day. R1's Service Recap Summary dated January 2026, indicated the following: -Daily blood pressure checks R1's record lacked prescriber orders for daily blood pressure and pulse checks. On January 21, 2026, at 7:58 a.m., clinical nurse supervisor (CNS)-B stated the licensee checked R1's blood pressure and pulse once daily and as needed. CNS-B stated R1's record lacked prescriber orders for daily blood pressure and pulse checks. The licensee's Treatment and Therapy Management policy dated November 13, 2025, indicated the RN will obtain orders or prescriptions for all treatments and therapies. The order will include the following elements: a. resident name b. description of the treatment or therapy to be provided c. frequency d. other pertinent information 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

Page: 1

Establishment Info

Twin Cities Loyal Holistic Car
860 Rogers Court
Eagan, MN 55123
Dakota County
Parcel:

Phone:

License Info

License: 0041173

Risk:
License: -1
Expires on: 12/31/2023
CFPM: Said Gure
CFPM #: FM188760; Exp: 7/7/2026

Inspection Info

Report Number: F1039261014
Inspection Type: Full - Single
Date: 1/20/2026 Time: 11:00 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 1
Total Priority 2 Orders: 1
Total Priority 3 Orders: 1
Delivery: Emailed

New Order: 4-200 Equipment Design and Construction

4-201.11GMN *Priority Level: Priority 3 CFP#: 47*

MN Rule 4626.0506G Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

COMMENT: COOKED TCS FOODS FROM PREVIOUS DAYS ARE HELD IN REFRIGERATOR. DISCONTINUE THIS PRACTICE AND COMPLY WITH ABOVE RULE.

Comply By: 1/20/2026 Originally Issued On: 1/20/2026

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: NO CHLORINE TEST STRIPS. ACQUIRE AND USE CHLORINE TEST STRIPS TO VERIFY CONCENTRATION.

Comply By: 1/27/2026 Originally Issued On: 1/20/2026

! New Order: 4-700 Sanitizing Equipment and Utensils

4-702.11 *Priority Level: Priority 1 CFP#: 16*

MN Rule 4626.0900 Sanitize utensils and food contact surfaces of equipment before use, after cleaning.

COMMENT: KITCHEN COUNTERS USED AS FOOD CONTACT SURFACES WITHOUT FIRST SANITIZING.

ESTABLISHMENT WILL PREPARE 100 PPM CHLORINE BLEACH SOLUTION AND USE FROM A SPRAY BOTTLE TO SANITIZE THESE SURFACES.

Comply By: 1/20/2026 Originally Issued On: 1/20/2026

Food & Beverage General Comment

COOKED DISH - COLD HOLD, COOLER - 41 DEGREES F
FREEZER - FROZEN

This inspection was completed as part of MDH HRD assisted living facility survey. The inspection was conducted with the person-in-charge and reviewed with MDH HRD nurse evaluator Kassie Marking.

The kitchen is of residential build and should serve food for same-day service only.

The kitchen has wood cabinets with hollow base and laminate countertops, laminate floor, painted walls and ceiling. These kitchen finishes and surfaces are in good repair, clean and well maintained.

A 2-compartment sink is present in kitchen. 1 compartment is designated for handwashing only.

A residential dishwashing machine is present in the kitchen.

Verified hand sink correctly set-up, gloves, illness policy, probe thermometer, UST thermometer.

Discussed the following with the person-in-charge: food source, foodborne illness symptoms and exclusion of ill employees, avoiding bare hand contact with ready to eat foods, handwashing, sanitizing, all orders on this report.

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 F1039261014 from 1/20/2026



Said Gure
person-in-charge

Aron Goodner,
Public Health Sanitarian 1
651-201-4910
aron.goodner@state.mn.us



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

Sanitizer Observations/Recordings

Page: 1

Establishment Info

Twin Cities Loyal Holistic Car
Eagan
County/Group: Dakota County

Inspection Info

Report Number: F1039261014
Inspection Type: Full
Date: 1/20/2026
Time: 11:00 AM

Sanitizing Equipment: Product: Hot Water; **Sanitizing Process:** Dish Machine
Location: Equal To 166.5 Degrees F.
Comment:
Violation Issued?: No

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL38188016	Date: 1/20/2026
Facility Name: Twin Cities Loyal Holistic Care	
Facility Address: 860 Rogers Ct., Eagan, MN 55123	

☒ TAG IDENTIFICATION: 0775

SCOPE/ SEVERITY: Level 3; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]
2. Egress doors shall be readily operable from the egress side without the use of a key or special knowledge. [Minn. Stat. 144G.45 subd. 2; MSFC 1010.2]

Comments: A buckle lock and a chain lock were both attached to the front door of the facility. These locks were mounted at least 72 inches from the floor. These locks were not approved and would not be readily openable from the egress side of the door. During the survey licensed assisted living director (LALD)-A removed both unapproved locking mechanisms from the door. The door should be maintained without additional locks or unapproved locks that may prevent ready egress.

3. 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: LALD-A opened egress windows in resident rooms, and the surveyor measured the openable area of each window during survey. The egress window in unoccupied resident room 5 measured 18 inches clear width, 33 inches clear height, and 594 square inches total openable area. The window in resident sleeping rooms 5 did not meet the minimum requirements for opening height, nor the minimum requirements for total openable area. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window.

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. Extension cords shall be used only with portable appliances. Extension cords marked for indoor use shall not be used outdoors. [Minn. Stat. 144G.45 subd. 2; MSFC 604.5]

Comments: Extension cords were in use to power multiple electronics in resident room 2. Extension cords should not be used in lieu of permanent wiring.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 1; Isolated

TIME PERIOD OF CORRECTION: Seven (7) days

1. The physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment are in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. [Minn. Stat. 144G.45 subd.2]

Comments:

A light fixture on the ceiling of resident room 5 was hanging by its wires and was not properly secured.

The closet in resident room 5 was missing a handle that had broken off.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Twenty One (21) days

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

Comments: No documentation of employee actions for evacuation was provided to the surveyor during survey. Licensed assisted living director (LALD)-A stated that the fire safety and evacuation plan (FSEP) binder had fallen apart prior to the survey, and that required documentation would be emailed to the surveyor. No further documentation was provided to the surveyor.

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

Comments: No documentation of resident actions for evacuation were provided to the surveyor during survey. Licensed assisted living director (LALD)-A stated that the FSEP binder had fallen apart prior to the survey and that required documentation would be emailed to the surveyor. No further documentation was provided to the surveyor.

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

Comments: No unique resident needs for evacuation were provided to the surveyor during survey. Licensed assisted living director (LALD)-A stated that the FSEP binder had fallen apart prior to the survey and that required documentation would be emailed to the surveyor. No further documentation was provided to the surveyor.

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

Comments: No records of staff trainings on the FSEP were provided to the surveyor during survey. Licensed assisted living director (LALD)-A stated that the FSEP binder had fallen apart prior to the survey, and that required documentation would be emailed to the surveyor. No further documentation was provided to the surveyor.

5. 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. [Minn. Stat. 144G.45 subd.2]

Comments: No records of resident trainings on the FSEP were provided to the surveyor during survey. Licensed assisted living director (LALD)-A stated that the FSEP binder had fallen apart prior to the survey, and that required documentation would be emailed to the surveyor. No further documentation was provided to the surveyor.