Electronically Delivered

May 28, 2026

Licensee
Patricia Health Care Services
1351 Gresham Avenue North
Oakdale, MN 55128

RE: Project Number(s) SL42876015

Dear Licensee:

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

The Minnesota Department of Health completed an initial survey on April 16, 2026, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00

The total amount you are assessed is $500.00. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a

hearing must be in writing and received by MDH within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

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

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

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

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

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	42876	A. BUILDING: _____ B. WING _____	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATRICIA HEALTH CARE SERVICES	1351 GRESHAM AVE N OAKDALE, MN 55128

(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: SL42876015-0 On April 14, 2026, through April 16, 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 Provisional Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	42876	A. BUILDING: _____ B. WING _____	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATRICIA HEALTH CARE SERVICES	1351 GRESHAM AVE N OAKDALE, MN 55128

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	42876	A. BUILDING: _____ B. WING _____	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATRICIA HEALTH CARE SERVICES	1351 GRESHAM AVE N OAKDALE, MN 55128

(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
0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated April 14, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	42876	A. BUILDING: _____ B. WING _____	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATRICIA HEALTH CARE SERVICES	1351 GRESHAM AVE N OAKDALE, MN 55128

(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
0 480	Continued From page 3 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complied with accepted health care, medical, and nursing standards for infection control related to gloving and hand hygiene for one of one employee (agent (A)-A). 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).	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	42876	A. BUILDING: _____ B. WING _____	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATRICIA HEALTH CARE SERVICES	1351 GRESHAM AVE N OAKDALE, MN 55128

(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
0 510	Continued From page 4 The findings include: A-A was hired March 1, 2026, to provide assisted living services. On April 15, 2026, at 7:34 a.m., the surveyor observed A-A complete hand hygiene at the kitchen sink and then begin to prepare R3's morning medications. At 7:39 a.m., A-A removed their gloves after administering eye drops to R3, and without completing hand hygiene put on clean gloves. At 7:48 a.m., after completing administration of R3's morning medications, A-A removed their gloves, and put on clean gloves without completing hand hygiene. A-A then began preparing R2's morning medications. At 7:50 a.m., A-A removed gloves, and then went to the kitchen to retrieve water for R2's medication administration. A-A again put on clean gloves without completing hand hygiene. At 7:54 a.m., after obtaining vital signs on R2, A-A removed gloves and put new gloves on without completing hand hygiene. At 8:03 a.m., A-A removed their gloves and then completed hand hygiene. On April 15, 2026, clinical nurse supervisor (CNS)-C stated staff are trained to complete hand hygiene before, after, and in between gloves changes. CNS-C stated they believed it was a common issue among staff as they tended to forget it was necessary. Additionally, CNS-C stated they would provide retraining for staff to reinforce the procedure. The licensee's 8.09 Hand Washing policy dated February 1, 2026, indicated that when conducting a procedure requiring the use of gloves, proper hand hygiene should be completed before donning gloves and after removing gloves.	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	42876	A. BUILDING: _____ B. WING _____	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATRICIA HEALTH CARE SERVICES	1351 GRESHAM AVE N OAKDALE, MN 55128

(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
0 510	Continued From page 5 The Centers for Disease Control's (CDC), "CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings" dated November 29, 2022, under section 5a.1-2 read: 1.) Require healthcare personnel to perform hand hygiene in accordance with Centers for Disease Control and Prevention (CDC) recommendations. 2.) Use an alcohol-based hand rub or wash with soap and water for the following clinical indications: a.) Immediately before touching a patient; b.) Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices; c.) Before moving from work on a soiled body site to a clean body site on the same patient; d.) After touching a patient or the patient's immediate environment; e.) After contact with blood, body fluids or contaminated surfaces; and f.) Immediately after glove removal. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	42876	A. BUILDING: _____ B. WING _____	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATRICIA HEALTH CARE SERVICES	1351 GRESHAM AVE N OAKDALE, MN 55128

(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
0 660	Continued From page 6 covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) for one of two staff (agent (A)-A). This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's TB facility risk assessment dated February 9, 2026, indicated the licensee was at a low risk. A-A was hired February 2, 2026, to provide assisted living services. A-A's record contained a QuantiFERON-TB Gold Plus test dated August 29, 2025, which indicated a negative result. A-A's TB test occurred 127	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	42876	A. BUILDING: _____ B. WING _____	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATRICIA HEALTH CARE SERVICES	1351 GRESHAM AVE N OAKDALE, MN 55128

(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
0 660	Continued From page 7 days prior to hire. Additionally, A-A record contained an incomplete and undated TB symptoms screening. On April 14, 2026, at 11:07 a.m., A-A stated they were aware of the required contents of the employee record. On April 15, 2026, at 1:42 p.m., clinical nurse supervisor (CNS)-C stated they were unaware a TB test greater than 90 days would be ineligible but they would ensure employee TB tests were completed upon hire moving forward. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record. The licensee's 8.16 Tuberculosis Screening policy dated February 1, 2026, indicated the licensee would establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report (MMWR). No further information was provided.	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	42876	A. BUILDING: _____ B. WING _____	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATRICIA HEALTH CARE SERVICES	1351 GRESHAM AVE N OAKDALE, MN 55128

(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
0 660	Continued From page 8 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff 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 maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	42876	A. BUILDING: _____ B. WING _____	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATRICIA HEALTH CARE SERVICES	1351 GRESHAM AVE N OAKDALE, MN 55128

(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
0 680	Continued From page 9 potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's undated EPP lacked evidence of the following required content: - a process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response; - subsistence needs for staff and patients; - procedures for tracking staff and patients; - policies and procedures for volunteers; - policies and procedures for providing care and treatments at alternate care sites under 1135 waiver; - contact information for Federal, State, tribal, regional, local emergency personnel staff, state licensing and certification agency and Minnesota Office of Ombudsman for Long Term Care. On April 15, 2026, at 2:29 p.m., house manager (HM)-B stated they were responsible for the development of the EPP and were in the process of completing it when the survey started. HM-B stated they would continue to work on the development of the plan. The licensee's 9.01 Emergency Preparedness Plan - Appendix Z Compliance policy dated February 1, 2026, indicated the licensee would	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	42876	A. BUILDING: _____ B. WING _____	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATRICIA HEALTH CARE SERVICES	1351 GRESHAM AVE N OAKDALE, MN 55128

(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
0 680	Continued From page 10 have in place an effective and compliant Emergency Preparedness Plan. The intent is the plan would be aligned with the Centers for Medicare and Medicaid Services State Operation Manual Appendix Z: "State Operations Manual Appendix Z - Emergency Preparedness for All Provides and Certified Supplier Types: Interpretive Guidance." Minnesota Administrative Rule 4659.0100 Emergency Disaster and Preparedness Plan dated August 11, 2021, indicated assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. The code references documents, specifications, methods, and standards in the State Operations Manual Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 690 SS=F	144G.43 Subdivision 1 Resident record (a) Assisted living facilities must maintain records for each resident for whom it is providing services. Entries in the resident records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure entries in the resident	0 690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	42876	A. BUILDING: _____ B. WING _____	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATRICIA HEALTH CARE SERVICES	1351 GRESHAM AVE N OAKDALE, MN 55128

(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
0 690	Continued From page 11 records were current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry for two of two residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 R2 was admitted February 15, 2026, to receive assisted living services. R2's record lacked inclusion of a signed service plan. R2's record contained a Resident Contract for Assisted Living dated March 15, 2026. R2's record contained an admission assessment dated February 25, 2026, indicating 10 days had lapsed from R2's date of admission to the licensee and the initial assessment. R2's record also included a 14-day assessment dated March 11, 2026, 24 days after R2's admission. R3 R3 was admitted March 11, 2026, to receive assisted living services. R3's record lacked inclusion of a signed service plan.	0 690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	42876	A. BUILDING: _____ B. WING _____	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATRICIA HEALTH CARE SERVICES	1351 GRESHAM AVE N OAKDALE, MN 55128

(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
0 690	Continued From page 12 R3's record contained a Resident Contract for Assisted Living dated March 11, 2026. R3's record contained an admission assessment dated February 15, 2026, which was dated 24 days prior to R3's date of admission. R3's record also contained a 14-day assessment dated 10 days prior to R3's admission date and initiation of services. On April 14, 2026, at 2:16 p.m., clinical nurse supervisor (CNS)-C stated the assessment forms in R2 and R3's records were copies of the original forms, and that the dates on the copies may have been entered incorrectly. CNS-C stated they were unable to provide the original copies as the forms were shredded. On April 15, 2026, at 1:24 p.m., CNS-C stated the reason the original assessment documentation was missing was that they were still learning their role at the time of R2 and R3's admissions. CNS-C stated they had developed a universal assessment tool and were in the process of transcribing information onto the new forms. The licensee's 2.38 Resident Record - Information and Content policy dated February 1, 2026, indicated entries in the resident records must be current, legible, permanently recorded, dated and authenticated with the name and title of the person making the entry. Resident records, whether written or electronic will be protected against loss, tampering, or unauthorized disclosure. No further information was provided. TIME PERIOD OF CORRECTION: Seven (7)	0 690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	42876	A. BUILDING: _____ B. WING _____	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATRICIA HEALTH CARE SERVICES	1351 GRESHAM AVE N OAKDALE, MN 55128

(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
0 690	Continued From page 13 days	0 690		
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure personal health and medical information was kept private for four of four 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: On April 14, 2026, at 11:22 a.m., during a tour of the facility, the surveyor observed a calendar posted on the wall of the licensee's main living area. The calendar contained resident names of all residents currently residing within the facility and information related to the upcoming medical	0 700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	42876	A. BUILDING: _____ B. WING _____	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATRICIA HEALTH CARE SERVICES	1351 GRESHAM AVE N OAKDALE, MN 55128

(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
0 700	Continued From page 14 appointments. Specifically, the calendar displayed the date, time and location of R2's primary care, podiatry, optometry, nephrology, audiology, and Cologuard test result lab appointments. In addition, the calendar displayed the date, time, and location of R3's upcoming primary care appointment. On April 15, 2026, at 1:42 p.m., clinical nurse supervisor (CNS)-C stated they initially did not see these postings as a privacy issue but agreed this information should not be posted in a public location. CNS-C stated they would take down these calendars and put them into the locked medication cabinets, and if residents requested, they would provide calendars to be posted within their rooms. The licensee's 2.35 Resident Record - Access & Storage policy dated February 1, 2026, indicated information in the resident record is confidential and all staff are responsible to make sure confidentiality is maintained for all resident records and information. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	42876	A. BUILDING: _____ B. WING _____	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATRICIA HEALTH CARE SERVICES	1351 GRESHAM AVE N OAKDALE, MN 55128

(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
01640	Continued From page 15 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 interview and record review, the licensee failed to finalize a service plan for two of two residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 R2 was admitted February 15, 2026, to receive assisted living services. On April 15, 2026, at 7:54 a.m., the surveyor	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	42876	A. BUILDING: _____ B. WING _____	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATRICIA HEALTH CARE SERVICES	1351 GRESHAM AVE N OAKDALE, MN 55128

(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
01640	Continued From page 16 observed R2 receiving medication management services from agent (A)-A. R2's diagnoses included type 2 diabetes. R2's record contained a Resident Contract for Assisted Living dated March 15, 2026. R2's record lacked inclusion of a signed service plan. R3 R3 was admitted March 11, 2026, to receive assisted living services. On April 15, 2026, at 7:39 a.m., the surveyor observed R3 receiving medication management services from A-A. R3's diagnoses included chronic obstructive pulmonary disease. R3's record contained a Resident Contract for Assisted Living dated March 11, 2026. R3's record lacked inclusion of a signed service plan. On April 15, 2026, at 8:52 a.m., house manager (HM)-B stated the licensee was still working with R2 and R3's case managers to complete the development of service plans. HM-B stated that neither R2 nor R3 have had a service plan developed by the licensee. On April 15, 2026, at 1:22 p.m., clinical nurse supervisor (CNS)-C stated they had not completed the service plans with R2 and R3 yet. The licensee's 6.08 Service Plan policy dated	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	42876	A. BUILDING: _____ B. WING _____	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATRICIA HEALTH CARE SERVICES	1351 GRESHAM AVE N OAKDALE, MN 55128

(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
01640	Continued From page 17 February 1, 2026, indicated residents receiving assisted living services will have a service plan in place. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01640		
01730 SS=F	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	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	42876	A. BUILDING: _____ B. WING _____	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATRICIA HEALTH CARE SERVICES	1351 GRESHAM AVE N OAKDALE, MN 55128

(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
01730	Continued From page 18 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 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 record with the required content for two of two residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 R2 was admitted February 15, 2026, to receive assisted living services.	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	42876	A. BUILDING: _____ B. WING _____	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATRICIA HEALTH CARE SERVICES	1351 GRESHAM AVE N OAKDALE, MN 55128

(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
01730	Continued From page 19 R2's diagnoses included type 2 diabetes. R2's record lacked inclusion of a signed service plan. R2's record contained a Resident Contract for Assisted Living dated March 15, 2026. On April 15, 2026, at 7:54 a.m., the surveyor observed R2 receiving medication management services from agent (A)-A. R2's record contained a medication management assessment dated February 25, 2026. R2's record lacked documentation of a medication management plan. R3 R3 was admitted March 11, 2026, to receive assisted living services. R3's diagnoses included chronic obstructive pulmonary disease. R3's record lacked inclusion of a signed service plan. R3's record contained a Resident Contract for Assisted Living dated March 11, 2026. On April 15, 2026, at 7:39 a.m., the surveyor observed R3 receiving medication management services from A-A. R3's record contained medication management assessment dated February 15, 2026. R3's record lacked documentation of a medication management plan.	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	42876	A. BUILDING: _____ B. WING _____	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATRICIA HEALTH CARE SERVICES	1351 GRESHAM AVE N OAKDALE, MN 55128

(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
01730	Continued From page 20 On April 14, 2026, at 1:50 p.m., clinical nurse supervisor (CNS)-C provided the surveyor a blank copy of the licensee's medication management plan template. CNS-C stated they were unable to locate R2's medication management plan but could fill out the blank form based off of their medication management assessment. On April 15, 2026, at 1:21 p.m., CNS-C stated they would ensure that medication management plans were completed after completion of the medication management assessment. CNS-C stated this was something that they had not gotten done with yet. The licensee's 7.03 Medication Management Individualized Plan policy dated February 1, 2026, indicated that for each resident receiving medication management services, the facility will prepare and include in the service plan a written statement of the medication management services that will be provided to the residents. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
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:	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	42876	A. BUILDING: _____ B. WING _____	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATRICIA HEALTH CARE SERVICES	1351 GRESHAM AVE N OAKDALE, MN 55128

(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 21 Based on observation, interview, and record review, the licensee failed to ensure prescription medications were securely locked in a substantially constructed compartment and permitted only authorized personnel to have access. This had the potential to affect all residents residing within 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 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: On April 14, 2026, at 11:22 a.m., during a tour of the facility the surveyor was able to access the licensee's medication storage cabinet without use of a key. The licensee's medication cabinet was unsecured for an unknown amount of time. The surveyor then completed an audit of the medication cabinet under the supervision of clinical nurse supervisor (CNS)-C. On April 15, 2026, at 8:42 a.m., the surveyor observed agent (A)-A access the medication storage cabinet without use of a key indicating again that the medication cabinet had been unsecured for an unknown amount of time. At 8:47 a.m., the surveyor observed A-A secure the medication storage cabinet using a key. On April 15, 2026, at 1:47 p.m., CNS-C stated it was their guess that staff were keeping the medication cabinet unsecured so the surveyor	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	42876	A. BUILDING: _____ B. WING _____	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATRICIA HEALTH CARE SERVICES	1351 GRESHAM AVE N OAKDALE, MN 55128

(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 22 could have access to the cabinet. CNS-C stated they would make sure the cabinet was locked when not in use. The licensee's 7.11 Medication Storage policy dated February 1, 2026, indicated medications will be kept securely locked and stored per manufacturer's directions. Only authorized staff will have access to stored medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure time sensitive medications were labeled with the date opened for one of two residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	42876	A. BUILDING: _____ B. WING _____	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATRICIA HEALTH CARE SERVICES	1351 GRESHAM AVE N OAKDALE, MN 55128

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01890	Continued From page 23 a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On April 14, 2026, at 11:29 a.m., during an audit of the licensee's medication storage cabinet, the surveyor observed the following undated time sensitive medications: - Anoro Ellipta 62.5mcg/25mcg inhaler belonging to R3. The inhaler's front label had a place to document the date in which the tray was opened and a place to write a discard date. Additionally, front label indicated there were 30 doses in the inhaler, however the counter indicated only 12 doses remained. The back label of the inhaler indicated the medication was to be discarded six weeks after opening the tray or when the counter reads zero. On April 15, 2026, at 1:11 p.m., clinical nurse supervisor (CNS)-C stated staff will be retrained to label time sensitive medications when they are opened and will make sure documentation was clearer going forward. The licensee's 7.35 Inhaler policy dated February 1, 2026, indicated inhaler medications must be administered according to the prescribers' orders and verified with the manufacturers requirements per instructions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	42876	A. BUILDING: _____ B. WING _____	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATRICIA HEALTH CARE SERVICES	1351 GRESHAM AVE N OAKDALE, MN 55128

(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
02290	Continued From page 24	02290		
02290 SS=F	144G.91 Subd. 2 Legislative intent The rights established under this section for the benefit of residents do not limit any other rights available under law. No facility may request or require that any resident waive any of these rights at any time for any reason, including as a condition of admission to the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee included within the residency agreement contract language which limited the rights of all of the residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 was admitted February 15, 2026, to receive assisted living services. R2's record contained a Resident Contract for Assisted Living dated March 15, 2026. The contract contained a document titled Resident Things to Know and included the following language which limited the rights of residents: - "For employee and resident safety, all residents are required to take their medications as ordered by their physician and/or psychiatrist. Some residents may be required to be at the medication area on time for medications and treatment.	02290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	42876	A. BUILDING: _____ B. WING _____	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATRICIA HEALTH CARE SERVICES	1351 GRESHAM AVE N OAKDALE, MN 55128

(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
02290	Continued From page 25 Medications must be taken in the presence of staff; - For employee and resident safety, all residents are required to bring a written medical after care summary of every medical and psychiatric appointment attended. Medications cannot be changed or administered without a written order from a physician or psychiatrist; - For employee and resident safety, all residents are required to sign out any narcotics that are dispensed to them; - For employee and resident safety, any resident going on pass must sign out their medications from staff member. If a resident returns with missing or lost medications, those medications will not be dispensed again until the next scheduled dose unless the resident obtains written permission from their health care provider and that provider releases the licensee from any responsibility or liability relating to the re-administration of those medications; - For employee and resident safety, violence will not be tolerated in the home. If there is a threat of actual violence, the residents' housing and services may be terminated immediately. If a resident is violent and/or aggressive to another resident, the housing and services contract may be terminated immediately; - All residents are required to attend all psychiatrist and medical, and social service appointments; - There are no street drugs, alcohol, or over the counter medications allowed on the property or in your room. Any violation of this rule will result in termination of your housing and services contract and notification of the appropriate law enforcement agencies; - We request that Resident return to the assisted living facility by 10 p.m. Residents are required to call when late to let staff know they are coming	02290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	42876	A. BUILDING: _____ B. WING _____	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATRICIA HEALTH CARE SERVICES	1351 GRESHAM AVE N OAKDALE, MN 55128

(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
02290	Continued From page 26 home. Visitors must check in with staff. Visitors must provide a picture ID before being admitted to the facility. They must also be on the residents' approved visitor list before gaining access to the building; - Residents must be properly clothed at all times. You must have a top, bottom, and something covering feet at all times; - Maintain good hygiene, you must shower and wear clean clothes; - Keep your room neat. Excess clutter will be removed; - You must notify staff when you leave the property and when you return. Sign out sheets are available at the house; - If you want an overnight pass; you must fill out a pass request form and sign out your medications. If you are under guardianship, the guardian must authorize the pass; - No borrowing cigarettes or money; - No sexual acts between residents are allowed on the property, and; - I agree to follow all the rules. I understand that if I choose to break the rules then I can be evicted from the licensee." On April 14, 2026, at 1:03 p.m., house manager (HM)-B stated the contract found in R2's record was the same record used by all residents. On April 15, 2026, at 1:33 p.m., clinical nurse supervisor (CNS)-C stated they were not aware the document would be considered a violation of resident rights and would remove the document from resident admission processes. The Minnesota Assisted Living FAQ indicates that in the event of a facility-initiated expedited termination, A pre-termination meeting is still required. See Rule 4659.0120, Subpart 11.A. "A	02290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	42876	A. BUILDING: _____ B. WING _____	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATRICIA HEALTH CARE SERVICES	1351 GRESHAM AVE N OAKDALE, MN 55128

(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
02290	Continued From page 27 facility seeking an expedited termination under Minnesota Statute section 144G.52, must comply with all of the requirements of this part." This includes pre-termination meeting requirements discussed in subpart 1. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02290		

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

Food & Beverage Inspection Report

Establishment Info

Patricia Health Care Services
1351 GRESHAM AVE N.

Oakdale, MN 55128
Washington County
Parcel:

Phone:
PATRICIAHEALTHCARE23@GMAIL.COM

License Info

License: HFID 42876

Risk:
License:
Expires on:
CFPM:
CFPM #: ; Exp:

Inspection Info

Report Number: F1031261145
Inspection Type: Full - Single
Date: 4/14/2026 Time: 12:30pm
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 2
Total Priority 2 Orders: 1
Total Priority 3 Orders: 3
Delivery: Emailed

New Order: 2-100 Supervision
2-102.12AMN *Priority Level: Priority 3 CFP#: 2*
MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.
COMMENT:
ESTABLISHMENT DOES NOT HAVE A CERTIFIED FOOD PROTECTION MANAGER (CFPM).
ENSURE 1 FULL-TIME EMPLOYEE HAS TAKEN AN APPROVED FOOD SAFETY COURSE AND AFTER COMPLETION APPLIES WITH STATE FOR CFPM.
LINKS PROVIDED IN EMAIL WITH REPORT.

Comply By: 4/14/2026 Originally Issued On: 4/14/2026

! **New Order: 3-300B Protection from Contamination: cross-contamination, eggs**
3-302.11A(1) *Priority Level: Priority 1 CFP#: 15*
MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.
COMMENT:
OBSERVED CORN STORED NEXT TO RAW CHICKEN IN REFRIGERATOR.
HAD CHICKEN MOVED TO LOWER RAW FOOD AREA.
STORE ALL COOKED AND READY-TO-EAT PRODUCTS ABOVE RAW MEATS.
REFRIGERATOR STORAGE DIAGRAM SENT WITH REPORT.

Comply By: Complied On Site Originally Issued On: 4/14/2026

New Order: 3-500A Microbial Control: cooling
3-501.13ABC *Priority Level: Priority 3 CFP#: 35*
MN Rule 4626.0380ABC Thaw TCS food by one of the following methods: 1. under mechanical refrigeration that maintains the food temperature at 41 degrees F (4 degrees C) or less; 2. completely submerged under running water at 70 degrees F (21 degrees C) or less with a velocity to remove loose particles on an overflow and the food is maintained at 41 degrees F (5 degrees C) or less; 3. in a microwave oven or; 4. as part of the cooking process.
COMMENT:
OBSERVED FROZEN FOOD THAWING IN SINK.
DISCONTINUE THAWING FOR IN AMBIENT AIR.
HAS STAFF PLACE FOOD IN BOWL IN SINK UNDER COLD RUNNING WATER.
ALWAYS USE AN APPROVED THAWING METHOD LISTED ABOVE.

Comply By: 4/14/2026 Originally Issued On: 4/14/2026

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:
ESTABLISHMENT DOES NOT HAVE SANITIZER TESTING KIT ON SITE.
SANI TEST STRIPS LEFT ON SITE.
PURCHASE KIT AND TEST SANI CONCENTRATION (50-200PPM BLEACH, 150-400PPM QUAT) ON REGULAR BASIS.

Comply By: 4/17/2026 Originally Issued On: 4/14/2026

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control
6-501.11 *Priority Level: Priority 3 CFP#: 55*
MN Rule 4626.1515 Maintain the physical facilities in good repair.
COMMENT:
GROUT BETWEEN TILE BACKSPLASH AND COUNTERTOP IS MISSING OR DAMAGED.
SILICONE GAP WITH 100% SILICONE.

Comply By: 5/5/2026 Originally Issued On: 4/14/2026

! **New Order: 7-200 Toxic Supplies and Applications**
7-204.11 *Priority Level: Priority 1 CFP#: 28*
MN Rule 4626.1620 Discontinue using chemical sanitizers, including chemical sanitizing solutions generated on site and other chemical antimicrobials on food-contact surfaces that do not meet the requirements specified in 40 CFR part 180, section 180.940, or part 180, subpart E, section 180.2020.
COMMENT:
SANI SPRAY USED FOR FOOD CONTACT SURFACES MEASURED > 200 PPM.
HAD STAFF REMAKE SANI SPRAY - TEST = 200PPM.
ALWAYS TEST SANI SPRAY FOR PROPER CONCENTRATION AFTER MAKING.

Comply By: Complied On Site Originally Issued On: 4/14/2026

Food & Beverage General Comment

Nurse Evaluator on site: Zachary Morth

All violations discussed with PIC during the inspection.

NOTES:
Facility has a residential kitchen with the following finishes:
Laminate flooring
Wood cabinetry
Composite countertops
Flat painted ceiling
2-comp sink with right basin designated for handwashing.

Since establishment has a residential kitchen (4626.0506(G)(2)) Same-day service only. No saving and reheating of foods or preparation of foods the day prior to eating. Any remaining food from meals to be removed/discarded at end of day.

Discussed the following with pic:
Hand washing
Ware washing and dish machine temp (160F or greater)
Illness and illness log
No undercooked foods and cooking temps

Pasteurized egg use

NOTE: ESTABLISHMENT HAS UNDERCOOKED EGGS ON MENU, BUT IS NOT PREPARING THEM FOR RESIDENTS. UNDERCOOKED EGGS REMOVED FROM MENU. PURCHASE PASTEURIZED EGGS IF UNDERCOOKING EGGS.

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 F1031261145 from 4/14/2026

Frank Otiemoria
Person in Charge

Chris Foster, REHS/RS
Public Health Sanitarian 3
651-201-4728
chris.j.foster@state.mn.us

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

Temperature Observations/Recordings

Establishment Info

Patricia Health Care Services
Oakdale
County/Group: Washington County

Inspection Info

Report Number: F1031261145
Inspection Type: Full
Date: 4/14/2026
Time: 12:30pm

Food Temperature: Product/Item/Unit: Fruit Punch**; Temperature Process:** Cold-Holding
Location: Refrigerator at 38 Degrees F.
Comment:
Violation Issued?: No

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

Sanitizer Observations/Recordings

Establishment Info

Patricia Health Care Services
Oakdale
County/Group: Washington County

Inspection Info

Report Number: F1031261145
Inspection Type: Full
Date: 4/14/2026
Time: 12:30pm

Sanitizing Chemical: **Product:** Chlorine**; Sanitizing Process:** Spray Bottle
Location: Kitchen **Greater Than** 200 PPM
Comment:
Violation Issued?: Yes

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

Sanitizing Chemical (CORRECTED): **Product:** Chlorine**; Sanitizing Process:** Spray Bottle
Location: Kitchen **Equal To** 200
Comment:
Violation Issued?: No

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** Pre-Soaked Towelettes
Location: Kitchen **Equal To** 400 PPM
Comment:
Violation Issued?: No