Electronically Delivered

February 13, 2026

Licensee
Seed Senior Living LLC
5422 West Old Shakopee Road
Bloomington, MN 55437

RE: Project Number(s) SL39442016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 13, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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

St - 0 - 0340 - 144g.30 Subd. 5 - Correction Orders - $500.00
St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

factor.

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

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

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

Renee L. Anderson

Renee L. Anderson, Supervisor
State Evaluation Team
Email: Renee.L.Anderson@state.mn.us
Telephone: 651-201-5871 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
	39442	A. BUILDING: _____ B. WING _____	01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEED SENIOR LIVING LLC	5422 WEST OLD SHAKOPEE ROAD BLOOMINGTON, MN 55437

(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: SL39442016-0 On January 12, 2026, through January 13, 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 three residents; three 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.	
0 340 SS=F	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever	0 340		

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0 340	Continued From page 1 the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or staff of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must: (1) document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to record actions taken to comply with all correction orders from a survey completed December 12, 2023. The lack of action to ensure compliance with regulations 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	0 340		

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0 340	Continued From page 2 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 result of the licensee's previous survey, concluded on December 12, 2023, was sent to the licensee via email on December 29, 2023. The communication indicated the licensee was granted an assisted living license. The longest time period for correction (the time frame in which the licensee must document and correct orders) was 21 days from the date the licensee received their results, or January 19, 2023. The licensee lacked documented corrective actions for the following previously cited orders: -0660, 144G.42 Subd. 9. Tuberculosis prevention and control; -0680, 144G.42 Subd. 10. Disaster planning and emergency preparedness plan; and -0970, 144.50 Subd. 5. Waivers of liability prohibited. The licensee remained out of compliance with the above-listed statutes, and correction orders were reissued as a result of the current survey, ending January 13, 2026. On January 13, 2026, at 12:02 p.m., licensed assisted living director (LALD)-A provided the licensee's previous initial assisted living survey results but lacked any documented plans of correction for the correction orders. LALD-A stated he believed he made some corrections after the initial survey but did not document any plans of correction.	0 340		

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0 340	Continued From page 3 The Minnesota Department of Health (MDH) Correction Order Documentation Guidelines, dated January 3, 2023, indicated, correction order documentation should include the following: -identify how each order was corrected related to each individual client(s)/employee(s) identified in the order; -identify how each order was corrected for all the provider's clients/employees identified in the order; and -identify what changes to the provider's systems and practices were made to ensure compliance with the specific statute. Include information about how the provider will maintain compliance in the future. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340		
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 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	0 480		

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0 480	Continued From page 4 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; (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:	0 480		

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0 480	Continued From page 5 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 January 12, 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		
0 510 SS=D	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	0 510		

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0 510	Continued From page 6 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 and interview, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control. The licensee failed to ensure direct care staff performed adequate hand hygiene (HH) for one of two employees (unlicensed personnel (ULP)-C). 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 was hired July 12, 2023, and provided direct care assistance for residents. On January 12, 2026, during a continuous observation from 12:22 p.m., through 12:32 p.m., the surveyor observed ULP-C assist R2. Without completing hand hygiene, ULP-C donned gloves, prepped and administered medications for R2. Next, ULP-C went to the kitchen area, doffed gloves in the garbage and then went back to the office area without completing HH. On January 13, 2026, during a continuous	0 510		

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0 510	Continued From page 7 observation from 8:02 a.m., through 8:41 a.m., the surveyor observed ULP-C assisting R2 and R3 with medication administration. ULP-C completed hand hygiene then donned gloves to prepare R3's medications. After administering and documenting medication administration for R3, ULP-C proceeded to prepare medications for R2 without completing HH or changing gloves. ULP-C administered and documented medication administration for R3. ULP-C remained in the office area and did not complete hand hygiene until the surveyor provided a reminder. On January 13, 2026, at 9:02 a.m., ULP-C stated he missed washing his hands before he provided medication administration the previous day and between resident medication administration today. ULP-C verbalized he did receive initial and annual handwashing training from the licensee and nurse. On January 13, 2026, at 9:07 a.m., clinical nurse supervisor (CNS)-B stated staff were trained on handwashing during orientation and annual training. CNS-B verbalized ULP-C was nervous during the observation, and that she planned to complete education with all employees on infection control and handwashing. The Centers for Disease Control and Prevention (CDC) guidance, CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, revised November 29, 2022, indicated standard precautions were to be used to care for all patients in all settings to include HH, and noted, "Use an alcohol-based hand rub or wash with soap and water for the following clinical indications: a. Immediately before touching a patient	0 510		

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0 510	Continued From page 8 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 f. Immediately after glove removal." The licensee's Infection Control policy, dated September 8, 2025, indicated "Handwashing 1. All persons may be carriers of disease-producing microorganisms and therefore a possible source of infection. 2. Caring for residents requires the hands to be almost constantly touching the resident, articles of clothing and equipment used for care. 3. Hands should be washed at the following times. a. After changing beds b. Before assisting with medications c. Before and after treatments d. After all pet care e. After housekeeping f. After emptying bedpans g. After assisting the resident to the toilet h. After removing items from the floor i. Before preparing food j. Before feeding residents k. After using the bathroom l. After coughing or sneezing m. After smoking n. After handling plants o. After removing gloves." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	0 510		

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0 510	Continued From page 9 days	0 510		
0 660 SS=E	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). The licensee failed to complete a current TB facility risk worksheet, ensure screening for active TB including history and symptom screening, and baseline testing (either by a two-step tuberculin skin test (TST) or a single interferon gamma release assay (IGRA) TB blood test) was completed and documented for two of three employees (clinical nurse supervisor (CNS)-B, unlicensed personnel (ULP)-C).	0 660		

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0 660	Continued From page 10 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: CNS-B CNS-B was hired November 19, 2025, and provided direct nursing cares and services to residents. On January 13, 2026, at approximately 8:50 a.m., the surveyor observed CNS-B assist ULP-C with R2 and R3's medication administration questions. CNS-B's employee record included a TB blood test, dated May 27, 2025, more than 90 days prior to hire date. ULP-C ULP-C was hired July 12, 2023, and provided direct cares and services to residents. On January 13, 2026, from 8:02 a.m., to 8:50 a.m., the surveyor observed ULP-C assist R2 and R3 with medication administration. ULP-C's employee record included a patient visit receipt dated July 13, 2023. The receipt indicated a TB blood test was performed, but lacked the TB blood test result. The record further lacked a TB history and symptom screening questionnaire as required.	0 660		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 660	Continued From page 11 On January 13, 2026, at 10:01 a.m., CNS-B stated she did not realize the TB test result must be within 90 days of hire date, and stated she did not have a more recent TB test documented. CNS-B verbalized she planned to get another TB test. On January 13, 2026, at 1:30 p.m., licensed assisted living director (LALD)-A stated, ULP-C was not able to obtain a copy of the TB test result for his employee file. LALD-A verbalized he could not find ULP-C's TB screening documentation. 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 a TB infection control program should include the following: a team responsible for TB infection control; a facility TB risk assessment; written TB infection control procedures; and HCW education. The guidelines also indicate 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-tuberculin skin test (first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients. Baseline TB screening should be documented in the employee's record. The licensee's Tuberculosis Screening/Prevention policy, dated September 8, 2025, indicated, "Seed Senior Living will observe the recommended precautions related to TB prevention as identified by the Centers for Disease Control and Prevention (CDC) and the Minnesota Department of Health (MOH). The	0 660		

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	39442	A. BUILDING: _____ B. WING _____	01/13/2026

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0 660	Continued From page 12 precautions include the following elements. -Risk Assessment -TB Screening -Staff Education." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule.	0 680		

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0 680	Continued From page 13 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness (EP) plan with all required content as defined in Centers for Medicare and Medicaid Services (CMS) Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's EP plan, last reviewed September 8, 2025, lacked evidence of the following required content: -documentation the missing resident policy was reviewed quarterly; -documentation of arrangement with other facilities; and -documentation of two emergency preparedness exercises (an annual full-scale exercise or individual facility-based functional exercise, a second full-scale exercise that was either community-based, an individual facility based functional exercise, a mock disaster drill, or a table-top exercise. On January 13, 2026, at 12:35 p.m., licensed assisted living director (LALD)-A stated he was aware of the requirement to review the missing resident policy quarterly but had not documented	0 680		

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0 680	Continued From page 14 or implemented this yet. Education provided. LALD-A stated he had not yet completed or documented, an annual full-scale exercise, a community-based functional exercise, an individual facility based functional exercise, a mock disaster drill, or a table-top exercise. Also, LALD-A verbalized he did not have contracts or agreements with the two hotels listed in emergency binder or transportation companies to use if needed. The licensee's Missing Resident policy dated September 8, 2025, indicated, "The missing resident procedure will be reviewed by the Director and Clinical Nurse Supervisor at least quarterly. Changes to the plan will be documented." The licensee's Emergency Preparedness policy dated September 8, 2025, indicated, "[Licensee] will 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. The plan considers the organization's commitment to provide services while ensuring the safety of its employees and residents. [Licensee] will implement the Emergency Management program* as soon as the agency becomes aware of the existence of an emergency." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment	0 775		

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0 775	Continued From page 15 Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated January 13, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The	0 810		

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0 810	Continued From page 16 plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the 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.	0 810		

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0 810	Continued From page 17 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 January 13, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure assisted living contracts did not include language waiving the licensee's liability for health, safety, or personal property of a	0 970		

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0 970	Continued From page 18 resident for one of one resident (R2). 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 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 on November 1, 2024, with diagnoses including physical vulnerable adult, chronic obstructive pulmonary disease (COPD, a lung disease), and alcoholic cirrhosis (permanent scarring) of the liver. R2's Service Plan (Waiver) - Addendum to Contract dated November 13, 2024, indicated R2 received services including assistance with housekeeping, laundry, meals, bathing, dressing, grooming, socialization, behavior management, continuous positive airway pressure (CPAP), oxygen, and medication administration. R2's Assisted Living contract dated November 1, 2024, included the following language indicating a waiver of licensee liability: "Miscellaneous Provisions: 1. Insurance Liability and Release. The resident shall maintain at all times his or her own health, personal property, liability, automobile (if applicable), and other insurance coverages and shall provide evidence of same by copies of binders or policies provided to [Licensee] upon request. The resident acknowledges that [Licensee] is not an insurer of the resident's person or property. The resident agrees that	0 970		

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0 970	Continued From page 19 [Licensee] will not be liable to the resident for any personal injury or property damage (including, without limitation, damage to, or loss or theft of, automobiles or personal property of resident) suffered by the resident or the resident's agents, guests or invitees, unless and to the extent that the injury or damage is caused by the negligence of [Licensee] or its employees or agents. The resident hereby releases [Licensee] from liability for any personal injury or property damage suffered by the resident or the resident's agents, guests, or invitees, unless caused by the negligence of [Licensee] or its employees or agents." R3 R3 was admitted on November 1, 2024, with diagnoses including psychotic behaviors, atrial fibrillation (an irregular heart rhythm, and difficulty regulating emotions. R3's Service Plan (Waiver) - Addendum to Contract dated, November 1, 2024, indicated R3 received services including assistance with housekeeping, laundry, meals, bathing, dressing, grooming, socialization, behavior management, and medication administration. R3's Assisted Living dated November 1, 2024, included the following language indicating a waiver of licensee liability: "Miscellaneous Provisions: 1. Responsibilities. The resident is responsible to protect their own interests outside what is covered in this Agreement. The resident acknowledges that [Licensee] is not an insurer of the resident's person or property. The resident agrees that resident shall be responsible for any personal injury or property damage (including, without limitation, damage to, or loss	0 970		

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0 970	Continued From page 20 or theft of, automobiles or personal property of resident) suffered by the resident or the resident's agents, guests or invitees, unless and to the extent that the injury or damage is caused by the negligence of [Licensee] or its employees or agents." On January 13, 2026, at 9:13 a.m., licensed assisted living director (LALD)-A stated he had worked on the contract a waiver of liability language in the contract with a consultant and believed it was corrected. Education provided to both LALD-A and clinical nurse supervisor (CNS)-B. LALD-A verbalized he planned to have the contract updated and reviewed with all the residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office	01060		

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01060	Continued From page 21 of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content after an emergency relocation, for one of three 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	01060		

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01060	Continued From page 22 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3 was admitted on November 1, 2024, with diagnoses including psychotic behaviors, atrial fibrillation (irregular heart rhythm), and difficulty regulating emotions. R3's Service Plan (Waiver) - Addendum to Contract dated, November 1, 2024, indicated R3 received services including assistance with housekeeping, laundry, meals, bathing, dressing, grooming, socialization, behavior management, and medication administration. R3's record included a Housing Report Summary dated November 1, 2024, to December 30, 2025, indicating R3 was transported and admitted to the hospital on the following dates: -March 15 to March 18; -June 11 to June 13; -September 26 to September 27; -October 2 to October 3; -October 3 to October 6; -October 24 to October 27; -November 18 to November 19; and -December 27 to December 30. R3's record lacked evidence of a written notice provided to the resident, the resident's legal representative, and designated representative on the previously listed dates, that contained at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident had been relocated	01060		

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01060	Continued From page 23 and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care (OOLTC); - if known and applicable, the approximate date or range of dates within which the resident was expected to return to the facility, or a statement that a return date was not currently known; and - a statement that, if the facility refused to provide housing or services after a relocation, the resident had the right to appeal and the contact information for the agency to which the resident may submit an appeal. On January 13, 2026, at 11:25 a.m., licensed assisted living director (LALD)-A stated he was not aware of the requirement to provide an emergency relocation notice for residents who were transported to the hospital, or to notify the OOLTC if a resident remained in the hospital for more than four days. LALD-A stated an emergency relocation notice, and notification was not completed for R3's hospitalizations. Education was provided to both LALD -A and clinical nurse supervisor (CNS)-B. Both LALD-A and CNS-B verbalized they planned to ensure the emergency relocation notifications were completed going forward. The licensee's Discharge and Transfer of Residents policy dated September 8, 2025, indicated, "25. In the event of an emergency relocation, the facility will, as soon as possible, provide written notice of Emergency Relocation to the following: a. The resident b. The resident's legal representative c. The resident's designated representative d. If the resident receives home and community-based services, the resident's case manager	01060		

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01060	Continued From page 24 e. If the resident has been relocated and not returned to Seed Senior Living within four (4) days, the Office of Ombudsman for Long-Term Care f. Notice of the right to appeal the decision under 144G.54 In addition, included, "26. The written notice shall include the following: a. The reason for the relocation b. Name and contact information for the location to which the resident has been located and any new service provider c. Contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities d. If known, the approximate date range within which the resident is expected to return to the facility or a statement that the date is not currently known e. A statement that, if the facility refuses to provide housing or services after a relocation, the resident has a right to appeal the decision and contact information for the person to whom the resident should submit the appeal." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual	01500		

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01500	Continued From page 25 training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication;	01500		

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01500	Continued From page 26 (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received at least eight (8) hours of annual training for each 12 months of employment, including the required topics, for one of two employees (unlicensed personnel (ULP)-C). 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 was hired July 12, 2023, and provided direct cares for residents. On January 12, 2026, at 12:22 p.m., the surveyor observed ULP-C assist R2 with prn (as needed) medication administration. ULP-C's employee record lacked evidence of 8	01500		

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01500	Continued From page 27 hours of required annual training completed in the last 12 months. ULP-C's employee record lacked evidence of annual training topics completed to include: -review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On January 13, 2026, at 10:50 a.m., licensed assisted living director (LALD)-A stated he missed assigning all the required annual training to ULP-C's online education program, so some of the required trainings were not completed. The licensee's Staff Orientation and Education policy, dated, September 8,2025, indicated, "13. All staff providing assisted living services will complete at least eight (8) hours of education for every twelve (12) months of employment. 14. Education topics will include, but not be limited to, the following a. Reporting of maltreatment of adults b. Review of Assisted Living Bill of Rights and staff responsibilities related to ensuring the exercise and protection of those rights c. Review of the organization ' s policies and procedures related to provision of assisted living services and how to implement them d. Infection control techniques used in the home i. Implementation of infection control standards based on current recommendations per the CDC****** ii. Hand washing techniques iii. Need for/use of personal protective	01500		

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01500	Continued From page 28 equipment (PPE), including: 1. Gloves 2. Gowns 3. Masks iv. Appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes and razor blades v. Disinfection of reusable equipment vi. Disinfection of environmental surfaces vii. Reporting of communicable diseases e. Effective approaches to use to problem solve when working with a resident ' s challenging behaviors and how to communicate with residents who have dementia, Alzheimer ' s Disease or related disorders (2 hours) f. The principles of person-centered planning and service delivery and how they apply to direct support services provided by staff g. Mental illness with de-escalation (1 hour)." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01530 SS=E	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date.	01530		

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01530	Continued From page 29 Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure employees completed dementia care training (at least eight hours within 180 working hours of the employment start date) for one of two employees (unlicensed personnel (ULP)-C), and two hours of initial training on mental illness and de-escalation topics for two of	01530		

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01530	Continued From page 30 two employees (clinical nurse supervisor (CNS)-B, ULP-C). 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: CNS-B CNS-B was hired November 19, 2025, and provided direct nursing cares and services to residents. CNS-B's online training transcript indicated CNS-B completed .75 hours of mental health training on November 19, 2025. CNS-B's employee record lacked documentation they completed the required 2 hours of initial training on mental illness and de-escalation topics within 160 hours of start date, effective July 1, 2025. ULP-C ULP-C was hired July 12, 2023, and provided direct cares and services to residents. ULP-C's online training transcript indicated ULP-C completed one hour of mental health training on October 2, 2023, and five hours of dementia training between July 18, 2023, to July 22, 2023.	01530		

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01530	Continued From page 31 ULP-C's employee record lacked documentation the required 2 hours of initial training was completed on mental illness and de-escalation topics within 160 hours of start date, effective July 1, 2025. In addition, ULP-C lacked the required dementia care training (at least eight hours within 180 working hours of the employment start date). On January 13, 2026, at 10:50 a.m., licensed assisted living director (LALD)-A confirmed ULP-C lacked eight hours of training on dementia care, and both CNS-B and ULP-C lacked two hours of training on mental illness and de-escalation topics. LALD-A stated he had not assigned all the required courses to the employees in the online education training program but planned to get these assigned. The licensee's Education on Dementia policy, dated, September 8, 2025, indicated, "3. Direct care employees must have completed at least eight (8) hours of initial education** within 160 working hours of the employment start date in the following topics: a. An explanation of Alzheimer's Disease and other dementias b. Assistance with activities of daily living (AOL's) c. Problem solving with challenging behaviors d. Communication skills e. Person-centered planning and service delivery." The licensee's Education on Mental Illness and De-escalation policy, dated, September 8, 2025, indicated, "3. Direct care employees must have completed at least two (2) hours of initial education** within 160 working hours of the employment start date in the following topics: a. Recognizing symptoms of common mental	01530		

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01530	Continued From page 32 illness diagnoses, including but not limited to mood disorders, anxiety disorders, trauma- and stress or related disorders, personality and psychotic disorders, substance use disorder, and substance misuse; b. De-escalation techniques and communication; and c. Crisis resolution and suicide prevention, including procedures for contacting county crisis response teams and 988 suicide and crisis lifelines." In addition, included, "4. Until the initial education is complete, an employee will not provide direct care unless there is another employee on site who has completed the initial two (2) hours of education on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and	01620		

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01620	Continued From page 33 the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the	01620		

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01620	Continued From page 34 licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment, utilizing a uniform assessment tool, no more than 90 days from the previous assessment for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On January 12, 2026, at 10:12 a.m., during the entrance conference, licensed assisted living director (LALD)-A stated the licensee completed nursing assessments upon admission, within 14 days of admission, every 90 days, and with a change in condition. R2 was admitted on November 1, 2024, with diagnoses including physical vulnerable adult, chronic obstructive pulmonary disease (COPD, a lung disease), and alcoholic cirrhosis (permanent scarring) of the liver. R2's Service Plan (Waiver) - Addendum to Contract dated, November 13, 2024, indicated R2 received services including assistance with housekeeping, laundry, meals, bathing, dressing, grooming, socialization, behavior management, continuous positive airway pressure (CPAP), oxygen, and medication administration. R2's medical record included an Assessment,	01620		

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01620	Continued From page 35 dated August 25, 2025, and a subsequent assessment dated January 8, 2026, greater than 90 days after the previous assessment. On January 13, 2026, at 9:29 a.m., LALD-A stated R2's 90-day assessment was completed late. LALD-A verbalized there was a change in nursing staff due to a medical leave of absence and the assessment was completed more than 90 days from the previous assessment for R2. Clinical nurse supervisor (CNS)-B stated she worked on the assessments as quickly as she could when she started her employment with licensee. The licensee's Assessment and Reassessment policy, dated, September 8, 2025, indicated, 8. Ongoing resident reassessments must be conducted by an RN and cannot exceed 90 days from the last date of assessment." No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01880 SS=D	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 store all prescription medications according to the manufacturer's	01880		

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01880	Continued From page 36 directions for one of three residents (R4). 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: R4 was admitted November 1, 2024, and diagnoses included schizoaffective disorder and diabetes. R4's Service Plan (Waiver) - Addendum to Contract, dated August 22, 2025, indicated R4 received services including assistance with activities of daily living, housekeeping, laundry, meals, blood glucose supervision, and medication management. R4's Medications - Current, dated January 13, 2026, indicated R4's active medication list included Lantus Solostar (long-acting insulin) 100 units (u) per milliliter (ml), self-set up, inject 90 units subcutaneously every morning. On January 12, 2026, at 10:12 a.m., during the entrance conference, clinical nurse supervisor (CNS)-B stated R4 administered her own medications. On January 12, 2026, at 1:15 p.m., the surveyor observed with unlicensed personnel (ULP)-C, a locked storage box stored in the kitchen refrigerator on the main floor of the facility. The	01880		

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01880	Continued From page 37 locked box contained one unopened box of and one opened box with four unopened Lantus Solostar insulin pens. ULP-C stated he thought the night shift possibly monitored and documented the refrigerator temperatures. The refigerator included a thermometer with a current temperature of 34 degrees Farenheit (F). On January 12, 2026, at 1:58 p.m., licensed assisted living director (LALD)-A stated they stored R4's unopened insulin for in a locked storage box in the kitchen refrigerator. LALD-A stated the employees retrieved R4's insulin for her as needed. LALD-A verbalized they were not currently monitoring the temperature of the refrigerator. Education provided. LALD-A verbalized he planned to monitor the refrigerator temperature daily. Lantus Solostar patient information booklet, dated, May 2023, indicated on page 13, "Keep any unopened pens in the fridge (not the freezer). The temperature should be between 2°C and 8°C [36-46°F]." The licensee's Storage/Control of Medications policy dated September 8, 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=D	144G.71 Subd. 20 Prescription drugs	01890		

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01890	Continued From page 38 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 medications were kept in the original container in which was dispensed by the pharmacy bearing the original prescription label 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 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3 was admitted on November 1, 2024, with diagnoses including psychotic behaviors, atrial fibrillation (irregular heart rhythm), and difficulty regulating emotions. R3's Service Plan (Waiver) - Addendum to Contract dated, November 1, 2024, indicated R3 received services including assistance with housekeeping, laundry, meals, bathing, dressing, grooming, socialization, behavior management, and medication administration.	01890		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01890	Continued From page 39 On January 13, 2026, at 8:18 a.m., the surveyor observed ULP-C assist R3 with medication administration. ULP-C stated he administered R3 the prn (as needed) Nicotine lozenge every two hours to assist with her nicotine cravings. R3 was also present, and verbalized she needed the lozenges every two hours. The nicotine lozenge container lacked the original container with a label with required information for all the resident's medications. On January 13, 2026, at 8:20 a.m., clinical nurse supervisor (CNS)-B was present during the medication observation with ULP-C and R3. CNS-B stated the nicotine lozenges should have been kept in the original packaging including the required prescription information for all resident medications. The licensee's Storage/Control of Medications policy dated September 8, 2025, indicated, "10. Prescription drugs, prior to being set up for immediate or later administration,must be kept in the original container(s) in which they were dispensed by the pharmacy bearing the original prescription label with legible information. 11. The medication is labeled completely and legibly. The medication label should contain the following. a. Prescription number and name of medication b. Strength and quantity c. Expiration date for time-dated drugs d. Directions for use e. Resident's name f. Prescriber's name g. Date issued h. Name and address of licensed pharmacy issuing the medication." No further information was provided.	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39442	A. BUILDING: _____ B. WING _____	01/13/2026

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SEED SENIOR LIVING LLC	5422 WEST OLD SHAKOPEE ROAD BLOOMINGTON, MN 55437

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01890	Continued From page 40 TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01940 SS=D	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:	01940		

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01940	Continued From page 41 Based on observation, interview, and record review, the licensee failed to develop an individual treatment and therapy management record with all required content for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On January 12, 2026, at 10:12 a.m., during the entrance conference, clinical nurse supervisor (CNS)-B stated R2 received CPAP (continuous positive airway pressure) treatment assistance. R2 was admitted on November 1, 2024, with diagnoses including physical vulnerable adult, chronic obstructive pulmonary disease (COPD, a lung disease), and alcoholic cirrhosis (permanent scarring) of the liver. R2's Service Plan (Waiver) - Addendum to Contract dated, November 13, 2024, indicated R2 received services including assistance with housekeeping, laundry, meals, bathing, dressing, grooming, socialization, behavior management, CPAP, oxygen, and medication administration. R2's assessment dated, January 8, 2026, included an activities of daily living (ADL) category titled Respiratory Equipment indicating R2 as independently using oxygen equipment,	01940		

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	39442	A. BUILDING: _____ B. WING _____	01/13/2026

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01940	Continued From page 42 and staff to check and remind if needed. Also, included, "Needs help with CPAP or BiPAP - Application /removal, specify: cpap," with no notes included. R2's Service Recap Summary - Month, dated January 2026, indicated R2 received assistance with the following treatments: -oxygen delivery daily at 10:00 p.m. On January 13, 2026, at 12:58 p.m., the surveyor observed R2's bedroom with CNS-B and R2. R2 stated she no longer used the CPAP machine because it was negatively impacting her sleep. R2 stated she used the oxygen via nasal cannula tubing at night. R2's the oxygen concentrator was located near her bed. Also, R2 stated she received extra nasal cannula tubing from the medical device company. When asked, R2 stated she set her oxygen concentrator at two liters when used. CNS-B stated she thought she still used her CPAP machine. CNS-B was not aware there was an oxygen concentrator in R2's bedroom. R2's medical record lacked an accurate individualized treatment and therapy plan that included: -an accurate statement of the type of services that will be provided; -documentation of specific resident instructions related to the treatment or therapy administration, and -procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services. On January 13, 2026, at 1:06 p.m., CNS-B stated she had not completed a treatment management	01940		

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01940	Continued From page 43 plan for R2 yet. CNS-B verbalized there were not clear instructions on the service delivery summary on how the employees should assist R2 with her oxygen administration. CNS-B stated she planned to get a treatment management plan with specific instructions completed for R2 and ensure the assessment accurately reflected R2's respiratory equipment needs. The licensee's Treatment and Therapy Management policy, dated, September 8, 2025, indicated, "6. The RN or licensed professional 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 d. Identification of treatment or therapy tasks delegated to unlicensed personnel e. 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		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained	02320		

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02320	Continued From page 44 and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure residents received appropriate care and services when staff failed to competently follow the medication administration procedure for one of one employee (unlicensed personnel (ULP)-C). 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 was hired July 12, 2023, and provided direct care for the licensee's residents. ULP-C's employee record included documentation of medication administration training and competencies completed October 31, 2024. The documented training included all routes and procedures including the "3 safety checks on the checklist" of medication administration. R2's Service Plan (Waiver) - Addendum to Contract dated, November 13, 2024, indicated R2 received services including assistance with	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02320	Continued From page 45 housekeeping, laundry, meals, bathing, dressing, grooming, socialization, behavior management, continuous positive airway pressure (CPAP), oxygen, and medication administration. R2's signed Provider Orders dated, October 24, 2025, included two prn (as needed) medications for R2: -rizatriptan (for migraine), 10 milligrams (mg), dissolve one tablet in mouth as needed; and -acetaminophen (for pain) 325 mg, two tablets every six hours as needed. On January 12, 2026, at 12:22 p.m., ULP-C was observed to administer two prn medications requested by R2. Without completing hand hygiene, ULP-C obtained the two requested prn medications from the locked medication cabinet in the facility office area. ULP-C prepared the two medications for R2. ULP-C did not compare the medications to the electronic medical record (EMR) nor perform 6 "rights" of medication administration (right resident, right medication, right date, right time, right route, and right dose) to ensure the medication was being administered properly. ULP-C handed R2 the oral medications with water. ULP-C documented the administration in the EMR. On January 12, 2026, at 12:32 p.m. ULP-C stated he was trained to administer medications to the residents by the licensee's previous nurse. ULP-C further stated he should have completed the 6 rights of medication administration before administering the prn medications to R2. On January 12, 2026, at 12:34 p.m., clinical nurse supervisor (CNS)-B stated she completed the staff training and would expect them to administer medications using the 6 rights; comparing the	02320		

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02320	Continued From page 46 medication to the EMR before administering. CNS-B verbalized she planned to follow up with education for all employees on medication administration. The licensee's Delegation of Assisted Living Tasks policy, dated August 1, 2021, indicated, "9. All home health aides providing delegated nursing services to residents of [Licensee] are oriented by the clinician prior to initiation of the service. This orientation may be verbal, written, electronic or on-site according to the clinician's judgment." The licensee's Medication Administration policy, dated September 8, 2025, indicated, "3. The Registered Nurse may delegate medication administration to an unlicensed staff member (home health aide) according to the following protocol. a. All home health aides have passed a competency evaluation with respect to all medication routes to be administered b. The Registered Nurse has prepared written instructions for the home health aide in the proper methods to administer medications with respect to each resident c. The Registered Nurse has communicated with/provided orientation to the home health aide regarding the individual needs of the resident." In addition, included, " 6. 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 specific to the residents, as appropriate	02320		

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02320	Continued From page 47 f. Side effects g. Resident allergies to medications." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

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

SEED SENIOR LIVING LLC
5422 WEST OLD SHAKOPEE ROAD
Bloomington, MN 55437
Hennepin County
Parcel:

Phone:

License Info

License: HFID 39442

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

Inspection Info

Report Number: F1013261002
Inspection Type: Full - Single
Date: 1/12/2026 Time: 01:00 pm
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 1
Total Priority 2 Orders: 1
Total Priority 3 Orders: 1
Delivery:

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: NO MN CFPM COULD BE VERIFIED DURING THE INSPECTION. COMPLY WITH RULE. THE MN CFPM INFORMATION WAS PROVIDED.
Comply By: 3/16/2026 Originally Issued On: 1/12/2026

! **New Order: 3-800 Highly Susceptible Population**
3-801.11C *Priority Level: Priority 1 CFP#: 26*
MN Rule 4626.0447C Discontinue serving raw or partially cooked animal foods or sprouts to a highly susceptible population.
COMMENT: PER STAFF HAMBURGERS AND RAW SHELL EGGS ARE SERVED UNDERCOOKED UPON CLIENT REQUEST. SOME CLIENTS PREFER THE HAMBURGERS PINK AND EGGS SERVED SUNNY SIDE UP. COMPLY WITH RULE. DISCUSSED REQUIRED FINAL COOK TEMPERATURES WITH STAFF AND MDH GUIDANCE PROVIDED.
Comply By: Complied On Site Originally Issued On: 1/12/2026

New Order: 4-300 Equipment Numbers and Capacities
4-302.13B *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.
COMMENT: HOT WATER SANITIZING DISH MACHINE IS USED TO SANITIZE WARE. NO TEST KIT MEETING THE ABOVE REQUIREMENT WAS AVAILABLE. COMPLY WITH RULE.
Comply By: 1/16/2026 Originally Issued On: 1/12/2026

Food & Beverage General Comment

The inspection was completed with the operator then reviewed with MDH Nurse Evaluator D. Hinnendael.

The establishment has a residential kitchen and serves food prepared on the same day. The kitchen has wood cabinets, vinyl floor, tile walls, laminate counter top, and a smooth painted ceiling.

A two basin sink is located in the kitchen. One basin is designated for hand washing.

Residential dish machine is available to wash ware. The dish machine should be run on the sanitize/high temperature cycle.

Discussed hand washing, ware washing, staff illness policy, temperature control, final cook temperatures, cleaning, serving

highly susceptible populations, food storage, and food handling procedures.

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 F1013261002 from 1/12/2026

Jerry Malloy

Abdirahman Mohamed
Operator

Jerry Malloy,
Public Health Sanitarian Supervisor
651-201-3998
jerry.malloy@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

SEED SENIOR LIVING LLC
Bloomington
County/Group: Hennepin County

Inspection Info

Report Number: F1013261002
Inspection Type: Full
Date: 1/12/2026
Time: 01:00 pm

Food Temperature: Product/Item/Unit: Cheese**; Temperature Process:** Cold-Holding
Location: Refrigerator at 41 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Milk**; Temperature Process:** Cold-Holding
Location: Refrigerator at 40 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Salmon**; Temperature Process:** Cold-Holding
Location: Freezer at 22 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

SEED SENIOR LIVING LLC
Bloomington
County/Group: Hennepin County

Inspection Info

Report Number: F1013261002
Inspection Type: Full
Date: 1/12/2026
Time: 01:00 pm

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Kitchen **Equal To** 160 Degrees F.
Comment:
Violation Issued?: No

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL39442016-0	**Date:** 1/13/2026
Facility Name: Seed Senior Living	
Facility Address: 5422 Old Shakopee Road, Bloomington, MN 55437	

☒ **TAG IDENTIFICATION: 0775**

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

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]

2. Single- and multiple-station smoke alarms shall be replaced when they fail to respond to operability tests or exceed ten years from the date of manufacture. Smoke alarms shall be replaced with smoke alarms having the same type of power supply. [Minn. Stat. 144G.45 subd. 2; MSFC 1103.8.1]

   Comments: The hard-wired smoke alarm in the main floor hallway by the bedrooms had been removed and replaced with a battery powered smoke alarm.

3. Occupancy separations shall be provided in Group I and Group R occupancies. These separations shall be constructed and maintained in accordance with the Building Code. Existing wood lathe and plaster in good condition or ½ inch gypsum wall board is acceptable where one-hour occupancy separations are required. [Minn. Stat. 144G.45 subd. 2; MSFC 1105.2]

   Comments: There was a large hole on the garage side of the common wall that separates the facility from the attached garage. The access door into the attic was open to attached garage.

☒ **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: The Seed Senior Living Fire Safety Policy dated September 8, 2025, had not been updated to provide employee actions to take in the event of fire or similar emergency specific to this this facility. There were sections in the plan that were not filled in.

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: There was no section in the FSEP that addressed the responsibilities or basic evacuation procedures resident should follow in case of fire or similar emergency.

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: There was no section in the FSEP that addressed the individual needs of residents for evacuation.

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: LALD-A stated they did not have documentation of employee training on the FSEP.

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: LALD-A stated they did not have documentation of resident training on the FSEP.