Electronically Delivered

May 20, 2026

Licensee
Gabby Care Homes LLC
1513 Pennsylvania Avenue North
Champlin, MN 55316

RE: Project Number(s) SL36011016

Dear Licensee:

On April 7, 2026, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on January 21, 2026. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the January 21, 2026 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on January 21, 2026, found not corrected at the time of the April 7, 2026, follow-up survey and/or subject to penalty assessment are as follows:

0775 - Fire Protection And Physical Environment - 144g.45 Subd. 2. (a) - $1,000.00

The details of the violations noted at the time of this follow-up survey completed on April 7, 2026 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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 outlined on the state form; however, plans of correction are not required to be submitted for approval.

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.

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.

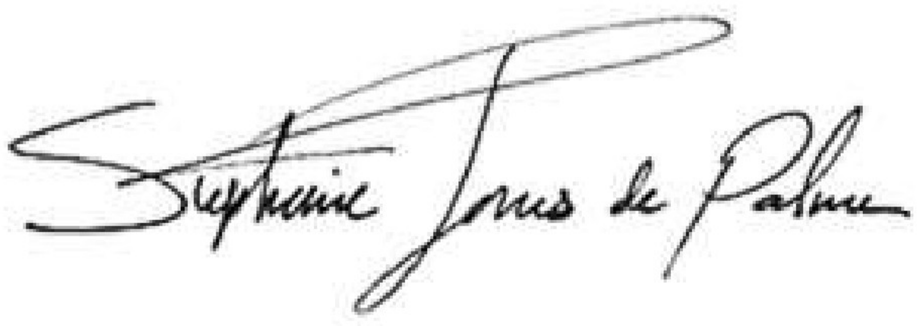
To submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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.

We urge you to review these orders carefully. If you have questions, please contact Stephanie Jones de Palma at 651-201-4320.

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

Sincerely,



Stephanie Jones de Palma, Supervisor
State Engineering Services Section
Health Regulation Division
Email: stephanie.jones.de.palma@state.mn.us
Telephone: 651-201-4320
Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36011	A. BUILDING: _____ B. WING _____	R 04/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GABBY CARE HOMES LLC - FAITH'S	1513 PENNSYLVANIA AVENUE NORTH CHAMPLIN, MN 55316

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL36011016-1 On April 7, 2026, the Minnesota Department of Health conducted a deck follow-up survey for the above provider to follow-up on orders issued pursuant to a survey completed on 1-21-26. As a result of the follow-up survey, the following orders were issued and/or reissued.	{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:	{0 340}	Not reviewed during this survey	
{0 470} SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable	{0 470}		

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{0 470}	Continued From page 2 unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by:	{0 470}	Not reviewed during this survey	
{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	{0 480}		

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{0 480}	Continued From page 3 and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (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	{0 480}		

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{0 480}	Continued From page 4 provided with a self-closing door. This MN Requirement is not met as evidenced by:	{0 480}	Not reviewed during this survey	
{0 650} SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by:	{0 650}	Not reviewed during this survey	

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{0 680}	Continued From page 5	{0 680}		
{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:	{0 680}	Not reviewed during this survey	
{0 775} SS=I	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:	{0 775}		

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{0 775}	Continued From page 6 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated April 7, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	{0 775}		
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.	{0 800}		

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{0 800}	Continued From page 7 This MN Requirement is not met as evidenced by:	{0 800}	Not reviewed during this survey	
{0 810} SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the 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	{0 810}		

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{0 810}	Continued From page 8 not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by:	{0 810}	Not reviewed during this survey	
{0 830} SS=F	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements, except a facility with a licensed resident capacity of six or fewer is exempt from rental licensing regulations imposed by any town, municipality, or county. This MN Requirement is not met as evidenced by:	{0 830}	Not reviewed during this survey	
{01760} SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the	{01760}		

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{01760}	Continued From page 9 reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by:	{01760}	Not reviewed during this survey	
{01890} SS=E	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:	{01890}	Not reviewed during this survey	

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL36011016-1	**Date:** 4/7/2026
Facility Name: GABBY CARE HOMES LLC	
Facility Address: 1513 Pennsylvania Ave N, Champlin, Minnesota 55316	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 3; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

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

2. Lighted matches, cigarettes, cigars or other burning object shall not be discarded in such a manner that could cause ignition of other combustible material. [Minn. Stat. 144G.45 subd. 2; MSFC 310.7]

   Comments: Cigarette butts were observed throughout the front landscaping and the front lawn.

Electronically Delivered

February 9, 2026

Licensee
Gabby Care Homes LLC - Faith's House
1513 Pennsylvania Avenue North
Champlin, MN 55316

RE: Project Number(s) SL36011016

Dear Licensee:

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

STATE CORRECTION ORDERS

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

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:

0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $1,000.00
0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - $1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $2,000.00**. 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.

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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,

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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36011	A. BUILDING: _____ B. WING _____	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GABBY CARE HOMES LLC - FAITH'S	1513 PENNSYLVANIA AVENUE NORTH CHAMPLIN, MN 55316

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL36011016-0 On January 20, 2026, through January 21, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were four residents all of whom received 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 provide sufficient documentation taken to comply with the correction orders from a survey completed April 11, 2024. The lack of action to ensure compliance with regulations had the potential to affect all residents of the licensee. 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: On April 25, 2024, the licensee received results from the previous survey concluded on April 11, 2024. The longest time period for correction (the time frame by which the licensee must document and correct orders) was 21 days from the date the licensee received their results, which was May 16, 2024. The licensee's correction orders included tag identifier 0680, related to 144G.42 Subd. 10. Disaster planning and emergency preparedness plan. On January 20, 2026, at 1:13 p.m., licensed assisted living director/registered nurse (LALD/RN)-D stated the licensee was in the process of updating the emergency preparedness plan (EPP) and they believed they would receive an order related to the EPP. LALD/RN-D stated the licensee attempted to create their own EPP however, they noticed they could not complete a EPP that was compliant appendix Z. LALD/RN-D stated the licensee was thinking about subcontracting someone to assist the licensee in creating an EPP. On January 21, 2026, at 12:39 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated the licensee corrected the orders issued after the previous survey however, they did not have a written plan of correction or documentation of what was done to correct the orders. LALD/CNS-C stated they were unaware the licensee needed a written plan of correction.	0 340		

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0 340	Continued From page 3 During the survey initiated on January 20, 2026, and exited on January 21, 2026, areas of deficient practice related to tag 0680 were identified and the correction order was re-issued. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and	0 470		

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0 470	Continued From page 4 (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the daily staff schedule was posted for residents, staff, and visitors to review. 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: On January 20, 2026, at 9:53 a.m., the surveyor observed a whiteboard located near the front entryway of the facility. The whiteboard read, "SunDay [sic] 01/11/2026 11 PM - 7 AM" and also contained a generic quote on the board. The surveyor did not observe a 24-hour staffing schedule posted in a central location. On January 20, 2026, at approximately 10:29 a.m., during the entrance conference with licensed assisted living/clinical nurse supervisor (LALD/CNS)-C, registered nurse (RN)-A, and licensed assisted living director/registered nurse (LALD/RN)-D, LALD/CNS-C stated the licensee's schedule was posted on the whiteboard near the front entryway. The surveyor inquired why the whiteboard the surveyor observed did not show a current daily staff schedule. LALD/CNS-C stated	0 470		

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0 470	Continued From page 5 they saw the whiteboard was not updated when they arrived at the facility, so they updated the board. The surveyor observed the whiteboard updated with the day shift staff information. LALD/CNS-C stated unlicensed personnel (ULP) were supposed to update the white board every shift when they entered the facility. LALD/RN-D stated they believed it was not updated by the oncoming ULP. The licensee's 4.06 Staffing & Scheduling policy dated August 1, 2021, indicated the clinical nurse supervisor (CNS) would develop a 24-hour daily staffing schedule. The daily work schedule must be posted after redacting direct-care members resident assignments, at the beginning of each work shift in a central location of the building accessible to staff residents, volunteers, and the public. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
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	0 480		

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0 480	Continued From page 6 CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (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.	0 480		

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0 480	Continued From page 7 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated January 20, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation:	0 650		

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0 650	Continued From page 8 (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to document competency evaluations with required content per Minnesota Administrative Rules chapter 4659.0190 Subp. 6. (training records and documentation) for two of two unlicensed personnel ((ULP)-B, ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	0 650		

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0 650	Continued From page 9 ULP-B ULP-B was hired on February 2, 2024, to provide assisted living services. ULP-B's employee record included the following documents: - Skill Competency Osha & Infection Control; - Skill Competency Personal Cares; - four different Skills Competency Client Mobility competency evaluations that included positioning, lifting and safe transfers, exercise and ambulation, and range of motion; - Skill Competency Vital Signs; - Skill Competency Dining, Nutrition and Food Safety; - Skill Competency Medication Administration - Routes; and - 13 different Skill Competency Medication & Treatment competency evaluations that included ace wrap, blood glucose, catheter care, compression stockings, CPAP, feeding tubes, insulin administration, insulin pens, nebulizer and inhalers, oxygen saturations, ostomy care, oxygen, and wound care. The documents listed above lacked the following required content: - the facility name, location, and license number; - total time spent on the competency evaluation; - printed name of the evaluator; and - name and title of the staff person completing the training, and the staff person's signature with a statement attesting that the staff person successfully completed the training as described in the training documentation. ULP-E ULP-E was hired on March 4, 2024, to provide assisted living services.	0 650		

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0 650	Continued From page 10 ULP-E's employee record included the following documents: - Skill Competency Osha & Infection Control; - Skill Competency Personal Cares; - four different Skills Competency Client Mobility competency evaluations that included positioning, lifting and safe transfers, exercise and ambulation, and range of motion; - Skill Competency Vital Signs; - Skill Competency Dining, Nutrition and Food Safety; - Skill Competency Medication Administration - Routes; and - 13 different Skill Competency Medication & Treatment competency evaluations that included ace wrap, blood glucose, catheter care, compression stockings, CPAP, feeding tubes, insulin administration, insulin pens, nebulizer and inhalers, oxygen saturations, ostomy care, oxygen, and wound care. The documents listed above lacked the following required content: - the facility name, location, and license number; - total time spent on the competency evaluation; - signature of the evaluator; and - the staff person's signature with a statement attesting that the staff person successfully completed the training as described in the training documentation. On January 21, 2026, at 12:50 p.m., licensed assisted living director/registered nurse (LALD/RN)-D stated the competency evaluation forms were generic and used for all ULP. LALD/RN-D stated the forms used for ULP were provided to them when the licensee first started their assisted living business. LALD/RN-D stated they were aware that the competency forms	0 650		

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0 650	Continued From page 11 lacked information and needed to be updated. The licensee's 4.05 Employee Records policy dated August 1, 2021, indicated employee records would be kept up to date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule.	0 680		

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0 680	Continued From page 12 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 20, 2026, at 1:05 p.m., the surveyor asked unlicensed personnel (ULP)-B for the licensee's EPP. ULP-B stated they did not know where it was located. The surveyor then observed ULP-B on the phone with an unknown person. ULP-B ended the phone call and stated to the surveyor that licensed assisted living director/registered nurse (LALD/RN)-D would bring the EPP to the facility. On January 20, 2026, at 1:13 p.m., the surveyor observed LALD/RN-D bring the licensee's EPP into the facility. LALD/RN-D stated the EPP was not kept onsite because they were working on updating it. LALD/RN-D stated the licensee attempted to create their own EPP however, they noticed they could not complete an EPP that was compliant with Appendix Z. LALD/RN-D stated the licensee was thinking about subcontracting	0 680		

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	36011	A. BUILDING: _____ B. WING _____	01/21/2026

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0 680	Continued From page 13 someone to assist the licensee in creating an EPP. The licensee failed to have an EPP available and onsite for staff, residents, and visitors. The licensee's EPP binder titled [the licensee's name] Emergency Operations Plan January 2023 lacked evidence of the following required content: - documentation of the missing resident plan reviewed quarterly; - accurate patient population; - substance needs for staff and resident; - arrangements with other facilities to include signed agreements; - roles under a waiver declared by secretary; - names and contact information to include resident physicians; and - emergency officials contact information. On January 21, 2026, at 10:32 a.m., LALD/RN-D stated they might have completed a comprehensive hazard vulnerability assessment however it may be located in the office. The surveyor requested a copy of the document. Licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated they reviewed the missing resident plan monthly at staffing meetings or quarterly. The surveyor requested documentation of the reviews. The surveyor inquired if the licensee's emergency preparedness plan addressed waiver 1135. LALD/RN-D stated they would look into it. Although requested, the surveyor did not receive the documents requested above prior to the conclusion of the survey. The licensee's 9.02 Disaster Planning and Emergency Preparedness policy dated August 1, 2021, indicated the licensee would have in place	0 680		

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0 680	Continued From page 14 a general emergency preparedness plan, that would comply with appendix Z. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 775 SS=I	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated 1-21-26, for the specific violations related the physical environment under Minnesota Statute 144G.	0 775		

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0 775	Continued From page 15 TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 780 SS=I	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation, interview, and record	0 780		

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0 780	Continued From page 16 review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated 1-21-26, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.	0 800		

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0 800	Continued From page 17 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 1-21-26, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency;	0 810		

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0 810	Continued From page 18 (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. 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	0 810		

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0 810	Continued From page 19 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 1-21-26, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 830 SS=F	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements, except a facility with a licensed resident capacity of six or fewer is exempt from rental licensing regulations imposed by any town, municipality, or county. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to follow applicable state and local laws, regulations, standards, ordinances, and codes related to smoking for three for four residents (R1, R2, R4). This had the potential to affect all residents, staff, and visitors.	0 830		

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0 830	Continued From page 20 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: R1 R1 admitted to the licensee on May 2, 2025, and began receiving assisted living services. R1's diagnoses included schizoaffective disorder (mental health disorder characterized by a combination of symptoms from both schizophrenia and mood disorders), bipolar (mental health condition characterized by significant mood swings including manic episodes and depressive episodes), autistic disorder, and substance use disorder for cannabis, methamphetamine and marijuana. R1's Service Plan (Waiver) - Addendum to Contract signed May 2, 2025, indicated R1 received assistance with socialization, bathing, behavior management, medication administration, oxygen and temperature monitoring, shopping assistance, and safety checks. R1's ongoing assessment dated November 1, 2025, indicated R1 was able to smoke safely, independently, without interventions. R1's progress note dated August 20, 2025, indicated staff cleaned R1's room and observed	0 830		

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0 830	Continued From page 21 smoked cigarette butts on the floor and the smoke detector removed from the wall. The note indicated registered nurse (RN)-A reviewed the smoking policy and reminded R1 where the designated smoking areas were located. R3 R3 admitted to the licensee on February 4, 2024, and began receiving assisted living services. R3's diagnoses included schizoaffective disorder and bipolar. R3's Service Plan (Waiver) - Addendum to Contract signed February 4, 2024, indicated R3 received assistance with bathing reminders, behavior management, housekeeping, laundry, medication administration, oxygen and temperature monitoring, shopping assistance, and safety checks. R3's ongoing assessment dated December 31, 2025, indicated R3 was able to smoke safely, independently, without interventions. R4 R4 admitted to the licensee on March 8, 2024, and began receiving assisted living services. R4's diagnoses included schizoaffective disorder, agitation requiring sedation protocol, anxiety, attention-deficit hyperactivity disorder, post-traumatic stress disorder, and psychosis. R4's Service Plan (Waiver) -Addendum to Contract signed March 12, 2024, indicated R4 received assistance with behavior management, housekeeping, laundry, meals, medication administration, shopping assistance, safety check, and oxygen, temperature, and weight	0 830		

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0 830	Continued From page 22 monitoring. R4's assessment dated December 16, 2025, indicated R4 was able to smoke safely, independently, without interventions. R4's Service Recap -By Resident - By Service dated December 21, 2025, through January 21, 2026, indicated R4 smoked indoors on January 2, 2026, January 11, 2026, and January 15, 2026. On January 2, 2026, R4 smoked in the living room no interventions were noted in the progress note. On January 11, 2026, R4 smoked in an unknown part of the facility and became aggressive. Staff attempted to decrease R4's aggression, however they were unable and called 911 for assistance. On January 15, 2026, R4 was smoking in an unknown area of the facility and made the fire alarms sound. Staff then redirected R4. On January 20, 2026, at 11:40 a.m., during a facility tour, the surveyor observed R1's room and observed a table with one smoked cigarette butt and ashes. The room had an odor of smoke. RN-A stated R1 had a behavior of smoking in their room during the winter. RN-A stated staff encouraged R1 to smoke outdoors. RN-A stated they had a conference related to R1 needing to smoke in designated areas last week. The surveyor requested documentation of the actions taken by the licensee once they realized R1 was smoking indoors. On January 21, 2026, at approximately 8:15 a.m., the surveyor observed R4 enter the kitchen and place a bowl and milk container on the kitchen counter. On January 21, 2026, at 8:20 a.m., the surveyor	0 830		

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0 830	Continued From page 23 observed the bowel and milk container noted above. The surveyor observed the bowl with one smoked cigarette butt and ashes, and the milk jug contained multiple smoked cigarette butts and ashes. On January 21, 2026, at 8:23 a.m., unlicensed personnel (ULP)-E stated R4 smoked in their room and put cigarette butts into containers. ULP-E stated when R4 smoked in their room they would need redirection to smoke outdoors. ULP-E stated they had not seen R4 smoking in their room however, they believed R4 smoked in their room during the night. On January 21, 2026, at 8:45 a.m., the surveyor requested documentation of actions the licensee had taken related to R4's indoor smoking. On January 21, 2026, at 10:41 a.m., licensed assisted living director/registered nurse (LALD/RN)-D stated residents who smoke indoors are given a first warning and if it continues the licensee holds a care conference followed by starting an eviction process. The surveyor inquired where they were in the process for R1. LALD/RN-D stated smoking indoors was new for R1 and there had been no reports made by ULP to management about R1 smoking indoors. LALD/RN-D stated they had not addressed smoking indoors with R1. LALD/RN-D stated indoor smoking was a "prevalent incident and we struggle with it." LALD/RN-D stated the licensee's cliental can become aggressive and staff needed to approach them in a specific manner in order to ensure staff safety. LALD/RN-D stated they believe this type of resident population needs more "stakeholders" to assist with this type of situation. LALD/RN-D stated R4 is a person who can verbalize	0 830		

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0 830	Continued From page 24 understanding when it comes to smoking compliance. LALD/RN-D stated R4 has not had a care conference related to indoor smoking. LALD/RN-D reiterated indoor smoking as being an issue within the facility. LALD/RN-A stated, "I cannot lie, it is a problem." LALD/RN-D reiterated how conversations from other organizations have made a major impact on compliance for indoor smoking at sister facilities. On January 21, 2026, at approximately 11:00 a.m., the surveyor observed no smoke detector in R4's room, ashes scattered around the room, and an odor of smoke. The surveyor inquired where R4 smoked. R4 stated they smoked outside. The surveyor inquired about the milk jug and the bowl that contained cigarette butts. R4 stated they were not theirs and they did not know who's they were. While continuing throughout the facility, the surveyor then observed burn marks and ashes near R3's windowsill and an odor of smoke in R3's room. On January 21, 2026, at 11:25 a.m., the surveyor requested documentation of actions the licensee had taken related to R3's indoor smoking. On January 21, 2026, at 11:47 a.m., R3 stated they smoked outdoors. The surveyor inquired if they smoked indoors ever. R3 stated, "not really". The surveyor inquired what not really meant. R4 stated it depended on what was going on if they smoked in their room or not however, R3 stated they smoked mostly outdoors. On January 21, 2026, at 12:37 p.m., the surveyor received the licensee's incident reports which did not contain any reports for indoor smoking. At the conclusion of the survey, the surveyor had	0 830		

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0 830	Continued From page 25 not received progress notes related to R3's smoking and documentation of actions taken by the licensee related to R3 and R4's indoor smoking. Minnesota State Statute 144.414 Prohibitions; Subdivision 3 dated 2025, indicated under a section titled Health care facilities and clinics: (a) Smoking is prohibited in any area of a hospital, health care clinic, doctor's office, licensed residential facility for children, or other health care-related facility, except that a patient or resident in a nursing home, boarding care facility, or licensed residential facility for adults may smoke in a designated separate, enclosed room maintained in accordance with applicable state and federal laws. The Minnesota Department of Health (MDH) document titled Minnesota Clean Indoor Air Act (MCIAA) dated September 7, 2023, indicated an indoor area means a space between a floor and a ceiling that is at least half enclosed by walls, doorways or windows around the perimeter. A wall included retractable dividers, garage doors, plastic sheeting or any other temporary or permanent physical barrier. In addition, smoking was prohibited at health care facilities and clinics. The licensee's 4.59 Smoking/Tobacco Use policy dated August 1, 2021, indicated smoking was only permitted in designated smoking areas outside the building. Smoking inside the facility was strictly prohibited to ensure the health and safety of all occupants. Enforcement and violations of the smoking policies may result in corrective action, including verbal or written warnings, fines, or other disciplinary measures as deemed necessary. In addition, the policy aligns with the United States Clean Air Act, which aims	0 830		

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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
0 830	Continued From page 26 to reduce air pollution and promote a healthy indoor and outdoor environment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 830		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to accurately transcribe one of three resident's (R4) prescriber orders into the medication administration record (MAR). 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	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36011	A. BUILDING: _____ B. WING _____	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GABBY CARE HOMES LLC - FAITH'S	1513 PENNSYLVANIA AVENUE NORTH CHAMPLIN, MN 55316

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01760	Continued From page 27 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 admitted to the licensee on March 8, 2024, and began receiving assisted living services. R4's diagnoses included schizoaffective disorder, agitation requiring sedation protocol, anxiety, attention-deficit hyperactivity disorder, post-traumatic stress disorder, and psychosis. R4's Service Plan (Waiver) -Addendum to Contract signed March 12, 2024, indicated R4 received assistance with behavior management, housekeeping, laundry, meals, medication administration, shopping assistance, safety check, and oxygen, temperature, and weight monitoring. On January 21, 2026, at 9:31 a.m., the surveyor observed unlicensed personnel (ULP)-E set up R4's medication with use of Residex (documenting software). The surveyor observed R4's MAR indicated a 21 milligram (mg) patch of nicotine was to be administered however, ULP-E prepared a 7 mg patch of nicotine and placed it with the other set up medication. ULP-E then provided R4 the nicotine patch for application. R4's prescriber order dated August 27, 2025, included nicotine 7 mg/24-hour transdermal patch place one patch over 24 hours onto the skin every 24 hours. R4's Med Admin Summary - Actual - Month dated January 2026 included nicotine 21 mg/ 24 hours transdermal patch place one patch to clean, dry,	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36011	A. BUILDING: _____ B. WING _____	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GABBY CARE HOMES LLC - FAITH'S	1513 PENNSYLVANIA AVENUE NORTH CHAMPLIN, MN 55316

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01760	Continued From page 28 hairless skin once daily, remove old patch before applying a new patch every 24 hours. The document indicated the patch had been applied 17 times from January 1 through January 21, 2026. On January 21, 2026, at 9:43 a.m., the surveyor inquired with ULP-E if they provided the correct nicotine patch. ULP-E stated yes, it is the small square patch and then asked to look at the medication box they administered from. ULP-E stated the nicotine patch they administered was 7 mg however, they believed R4's nicotine order was changed to 7 mg, and it was not updated in the Residex system. ULP-E stated they were going to contact the nurse about the discrepancy. On January 21, 2026, at 10:14 a.m., licensed assisted living director/registered nurse (LALD/RN)-D stated R4's medical record had a transcription error for nicotine transdermal patch. On January 21, 2026, at 12:59 p.m., registered nurse (RN)-A provided the surveyor a prescription for R4's nicotine transdermal patch. RN-A stated there was a transcription error however, R4 received the correct dose. RN-A stated they were unaware of why R4's MAR was not updated with the current prescription for the nicotine transdermal patch. The licensee's 7.22 Medication & Treatment Record - Documentation & Refusal policy dated August 1, 2021, indicated the following must be documented in the resident medication record after providing medication assistance or administration: - date; - time; - quantity of dose;	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36011	A. BUILDING: _____ B. WING _____	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GABBY CARE HOMES LLC - FAITH'S	1513 PENNSYLVANIA AVENUE NORTH CHAMPLIN, MN 55316

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01760	Continued From page 29 - method of administration; and - signature and title of authorized person who provided the assistance or administration of medication. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01890 SS=E	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 discard expired medication for two of six residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a 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:	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36011	A. BUILDING: _____ B. WING _____	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GABBY CARE HOMES LLC - FAITH'S	1513 PENNSYLVANIA AVENUE NORTH CHAMPLIN, MN 55316

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01890	Continued From page 30 On January 20, 2026, at 10:04 a.m., the surveyor observed the licensee's medication closet from which unlicensed personnel (ULP) dispensed medication from, and observed the following expired medications: - R2: one bubble pack that contained prazosin 2 milligrams (mg), mirtazapine 15 mg, olanzapine 15 mg, and gabapentin 300 mg with and expiration date of October 14, 2025, 10 bubble packs that contained prazosin 2 mg, mirtazapine 15 mg, olanzapine 15 mg, and gabapentin 300 mg with and expiration date of November 10, 2025, and 9 bubble packs that contained naltrexone 50 mg, and two capsules of gabapentin 300 mg with an expiration date of 11/10/2025; and - R3: hydroxyzine hydrochloride (HCL) 25 mg with an expiration date of November 28, 2025, and fluticasone propionate nasal spray 50 micrograms (mcg) with an expiration date of December 2025. On January 20, 2026, at 11:07 a.m., during an interview with licensed assisted living director/registered nurse (LALD/RN)-D, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C, and registered nurse (RN)-A, RN-A stated the nurses audited the medication closet once per month when medications arrived from the pharmacy. RN-A stated ULP were trained to take expired medications out of the resident bins and notify the nurse so the expired medications could be destroyed. LALD/RN-D stated R2 came to the facility with the medications listed above. RN-A stated R2 used those medications until the pharmacy was able to deliver. LALD/RN-D stated staff were trained not to dispense medications packaged from a different facility so the medication listed above for R2 would not be used.	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36011	A. BUILDING: _____ B. WING _____	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GABBY CARE HOMES LLC - FAITH'S	1513 PENNSYLVANIA AVENUE NORTH CHAMPLIN, MN 55316

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01890	Continued From page 31 The licensee's 7.23 Medication Disposal policy dated August 1, 2021, indicated the facility shall dispose of any medications remaining in the facility that were expired according to state and federal regulations for disposition of medication and controlled substances. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

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

GABBY CARE HOMES LLC - FAITH'S
1513 Pennsylvania Avenue North
Champlin, MN 55316
Hennepin County
Parcel:

Phone:

License Info

License: HFID 36011

Risk:
License:
Expires on:
CFPM: Joy M. Morabu
CFPM #: 16644; Exp: 2/9/2028

Inspection Info

Report Number: F8041261010
Inspection Type: Full - Single
Date: 1/20/2026 Time: 11:00 am
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 1
Total Priority 3 Orders: 2
Delivery: Emailed

New Order: 3-500C Microbial Control: date marking
3-501.17A *Priority Level: Priority 2 CFP#: 23*
MN Rule 4626.0400A Mark the refrigerated, ready-to-eat, TCS food prepared and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded.
COMMENT: ISSUED 4/11/24 (REPEAT): TCS FOODS SUCH AS DELI MEAT, MILK AND CREAM CHEESE NOT DATE MARKED. DATE MARK AS STATED ABOVE TO ENSURE TCS FOODS ARE USED WITHIN 7 DAYS.
Comply By: 1/20/2026 Originally Issued On: 1/20/2026

New Order: 4-500 Equipment Maintenance and Operation
4-501.11AB *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.
COMMENT: THE HANDLE ON THE TOP OVEN IS IN POOR REPAIR.
Comply By: 3/20/2026 Originally Issued On: 1/20/2026

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control
6-501.12A *Priority Level: Priority 3 CFP#: 55*
MN Rule 4626.1520A Clean and maintain all physical facilities clean.
COMMENT: THE WALL BEHIND THE OVEN HAS A BUILD-UP OF GREASE/FOOD DEBRIS.
Comply By: 1/27/2026 Originally Issued On: 1/20/2026

Food & Beverage General Comment

Inspection was completed with the house manager, Faith. Ashley Crews was the lead Health Regulation Division Nurse Evaluator. Facility had four residents at time of inspection.

This establishment has a residential kitchen. Food must be prepared for same say service only. The kitchen has wood cabinets with a hollow base, solid countertop, textured ceiling and vinyl flooring.

Dish machine has sani rinse cycle option and achieved a utensil surface temperature of at least 160F for sanitizing.

Discussed the following:
- Employee illness policy and logging requirements

- Reporting foodborne illness complaints to the health dept.
- Handwashing
- Date marking
- Glove-use and bare hand contact
- Proper food storage
-Vomit clean-up procedures
- Restrictions concerning serving a highly susceptible population

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 F8041261010 from 1/20/2026

Sam Obwaya

Sarah Conboy,
Public Health Sanitarian Supervisor
651-201-3984
sarah.conboy@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

GABBY CARE HOMES LLC - FAITH'S
Champlin
County/Group: Hennepin County

Inspection Info

Report Number: F8041261010
Inspection Type: Full
Date: 1/20/2026
Time: 11:00 am

Food Temperature: Product/Item/Unit: milk**; Temperature Process:** Cold-Holding
Location: Kitchen cooler at 39 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: ham**; Temperature Process:** Cold-Holding
Location: Kitchen cooler at 37 Degrees F.
Comment:
Violation Issued?: No

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL36011016-0	**Date:** 1/21/2026
Facility Name: GABBY CARE HOMES LLC	
Facility Address: 1513 Pennsylvania Ave N, Champlin, Minnesota, 55316	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 3; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

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

2. The means of egress shall be maintained free of obstructions or impediments to full instant use in case of fire or other emergency. [Minn. Stat. 144G.45 subd. 2; MSFC 1031.2]

   Comments: Resident room FH4 had obstructions in the window that would impede emergency egress.

3. Lighted matches, cigarettes, cigars or other burning object shall not be discarded in such a manner that could cause ignition of other combustible material. [Minn. Stat. 144G.45 subd. 2; MSFC 310.7]

   Comments: Cigarette butts were observed on the ground around the front entrance.

   Cigarette butts were observed on the floor throughout the facility.

4. Multiplug adapters, such as cube adapters, unfused plug strips or any other device not complying with NFPA 70 shall be prohibited. [Minn. Stat. 144G.45 subd. 2; MSFC 604.4]

   Comments: Multiplug adapters were observed being used in resident room FH4.

5. Extension cords and flexible cords shall not be a substitute for permanent wiring and shall be listed and labeled in accordance with UL 817. Extension cords and flexible cords shall not be affixed to structures, extended through walls, ceilings or floors, or under doors or floor coverings, nor shall such cords be subject to environmental damage or physical impact. Extension cords shall be used only with portable appliances. Extension cords marked for indoor use shall not be used outdoors. [Minn. Stat. 144G.45 subd. 2; MSFC 604.5]

Comments: Noncompliant extension cords were observed in resident room FH3.

☒ **TAG IDENTIFICATION: 0780**

SCOPE/ SEVERITY: Level 3; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

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1. Smoke alarms are provided in each room used for sleeping purposes. [Minn. Stat. 144G.45 subd.2]

   Comments: Smoke alarms were missing in resident room FH4, and FH1.

2. Smoke alarms are provided outside and in immediate vicinity of each room used for sleeping purposes. [Minn. Stat. 144G.45 subd.2]

   Comments: Smoke alarm was missing in the hallway outside resident room FH4.

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

   Comments: A test of the smoke alarms was conducted by licensed assisted living director/registered nurse (LALD/RN)-D and it was observed that the smoke alarms in the facility were not interconnected.

☒ **TAG IDENTIFICATION: 0800**

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

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

   Comments: The flooring in the main level bathroom was missing grout and had loose tiles.

   The wall within the stairwell leading to the lower level had holes.

   The walls in resident rooms FH1 and FH2 had multiple holes in the walls throughout the resident rooms.

☒ **TAG IDENTIFICATION: 0810**

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

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

   Comments: The FSEP was not readily available at the facility when the surveyor requested the information. Licensed assisted living director/registered nurse (LALD/RN)-D called the office to bring the documentation to the facility.

2. 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 provided FSEP was from a third-party provider and had not been updated to the specific facility.

3. 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/RN-D stated they offer the training, but the residents never attend. No documentation was available showing the training was offered.