Electronically Delivered

June 17, 2026

Licensee
Goshen Concept Care LLC
1352 Calumet Avenue
West Saint Paul, MN 55118

RE: Project Number(s) SL40630015

Dear Licensee:

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

The Minnesota Department of Health completed an initial survey on May 6, 2026, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - $500.00

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

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

The correction order documentation should include the following:

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

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

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

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

this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by MDH within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

KKM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40630	A. BUILDING: _____ B. WING _____	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOSHEN CONCEPT CARE LLC	1352 CALUMET AVENUE WEST SAINT PAUL, MN 55118

(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: SL40630015 On May 5, 2026, through May 6, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were two residents; two receiving services under the Provisional Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment	0 550		

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0 550	Continued From page 1 All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post in a conspicuous place, information about the facility's grievance procedure with the required content. This had the potential to affect the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On May 5, 2026, at 1:20 p.m. during a facility tour	0 550		

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0 550	Continued From page 2 with assistant licensed assist living director (ALALD)-A, the surveyor did not observe a posting with information about the facility's grievance procedure including the name and address information for the individuals who are responsible for handling resident grievances. ALALD-A stated the grievance procedure did not include the name and address information for the individuals who are responsible for handling resident grievances. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include all the required content for one of one resident (R1).	0 630		

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0 630	Continued From page 3 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 was admitted on May 27, 2025, with diagnosis that included Picks disease (a specific type of dementia). R1's record included an IAPP dated May 5, 2026. R1's IAPP lacked assessment of the resident's susceptibility to abuse other vulnerable adults and if applicable, the specific measures to be taken to minimize the risk of abuse to other vulnerable adults. On May 6, 2026, at 10:43 a.m., administrator (A)-C and assistant licensed assisted living director (ALALD)-A stated R1's file lacked assessment of the resident's susceptibility to abuse other vulnerable adults and specific measures to be taken to minimize the risk. The licensee's undated, Abuse Prevention Plan policy indicated the Minnesota requirement that the facility's individual abuse prevention plan includes an assessment of the vulnerable adult's susceptibility to abuse, the plan shall include an assessment of the individual's risk of abusing other vulnerable adults. The plan should then include measures to minimize the risk of abuse to the resident or to other vulnerable adults.	0 630		

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0 630	Continued From page 4 No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop a written	0 680		

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0 680	Continued From page 5 emergency preparedness plan (EPP) with all the required content defined in Appendix Z. This had the potential to affect residents receiving services under the assisted living license, 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 May 5, 2026, at 1:05 p.m. during the facility tour with administrator (A)-C, the surveyor observed the building to have three floors, including a main floor with an office, kitchen, living room, and resident rooms. The basement and upstairs floors had resident rooms. The licensee's emergency preparedness plan dated January 2026, was reviewed on May 6, 2026, at 1:40 p.m. with A-C. The plan lacked the following required content: - policies and procedures to address volunteers; and - policy and procedure to address the role of the facility under a waiver declared by the Secretary in accordance with section 1135 of the Act. On May 6, 2026, at 1:42 p.m., A-C and assistant licensed assisted living director (ALALD)-A stated the policy and procedure to address volunteers and policy and procedure to address 1135 waiver were both missing from the EPP and would add	0 680		

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0 680	Continued From page 6 them right away. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the	0 730		

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0 730	Continued From page 7 resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the resident record included the required documentation of all provided services as identified in the service plan for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted on May 27, 2025, with diagnosis that included Picks disease (a specific type of	0 730		

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0 730	Continued From page 8 dementia). On May 6, 2026, at 7:24 a.m., the surveyor observed owner/unlicensed personnel (O/ULP)-D administer R1's morning medications. R1's service plan dated May 27, 2025, indicated R1 received services to include assistance with hair care, grooming, toileting, bathing, stand by assistance, medication reminders, treatment exercises, modified diet, medication administration, laundry, housekeeping, and "I'm ok" check. R1's record lacked documentation of the following services provided: -hair care -grooming -toileting -bathing -stand by assistance -medication reminders -treatment exercises -modified diet -laundry -housekeeping - "I'm ok" checks R2 R2 was admitted on June 2, 2025, with diagnosis that included diabetes. R2's service plan dated June 2, 2025, indicated R2 received services to include assistance with hair care, grooming, toileting, bathing, stand by assistance, medication reminders, treatment exercises, modified diet, medication administration, laundry, housekeeping, and "I'm ok" check.	0 730		

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0 730	Continued From page 9 R2's record lacked documentation of the following services provided: -hair care -grooming -toileting -bathing -stand by assistance -medication reminders -treatment exercises -modified diet -laundry -housekeeping -"I'm ok" checks On May 6, 2025, at 11:14 a.m., administrator (A)-C stated R1 and R2's record lacked documentation of the services provided as listed above. A-C stated they should be using the electronic medical record to document services. The licensee's Resident Records policy undated indicated the resident record would contain documentation that services have been provided as identified in the service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
0 780 SS=F	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	0 780		

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0 780	Continued From page 10 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 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).	0 780		

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0 780	Continued From page 11 The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated May 6, 2026, 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. 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	0 800		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOSHEN CONCEPT CARE LLC	1352 CALUMET AVENUE WEST SAINT PAUL, MN 55118

(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
0 800	Continued From page 12 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 May 6, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans 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	0 810		

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0 810	Continued From page 13 their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated May 6, 2026, for the specific violations related the physical environment under Minnesota Statute 144G.	0 810		

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0 810	Continued From page 14 TIME PERIOD FOR CORRECTION: Twenty One (21) days.	0 810		
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to execute a written contract with the required content for two of two residents (R1, R2). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted on May 27, 2025, with diagnosis	0 910		

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0 910	Continued From page 15 that included Picks disease (a specific type of dementia). On May 6, 2026, at 7:24 a.m., the surveyor observed owner/unlicensed personnel (O/ULP)-D administer R1's morning medications. R1's service plan dated May 27, 2025, indicated R1 received services to include assistance with hair care, grooming, toileting, bathing, stand by assistance, medication reminders, treatment exercises, modified diet, medication administration, laundry, housekeeping, and "I'm ok" check. R1's Assisted Living Contract was dated May 27, 2025. The contract lacked the authorized agent for the facility. R2 R2 was admitted on June 2, 2025, with diagnosis that included diabetes. R2's service plan dated June 2, 2025, indicated R2 received services to include assistance with hair care, grooming, toileting, bathing, stand by assistance, medication reminders, treatment exercises, modified diet, medication administration, laundry, housekeeping, and "I'm ok" check. R2's Assisted Living Contract was dated June 2, 2025. The contract lacked the authorized agent for the facility. On May 6, 2026, at 8:36 a.m., assistant licensed assisted living director (ALALD)-A and administrator (A)-C stated the authorized agent for the facility is missing. A-C stated the information is on the Uniform Disclosure of	0 910		

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0 910	Continued From page 16 Assisted Living Services and Amenities (UDALSA), but not on the contract. The licensee's undated, Assisted Living Contracts policy indicated the contract must include managing agent of the facility and/or authorized agent of the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 910		
0 920 SS=C	144G.50 Subd. 2 (c) Contract information (c) The contract must include: (1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; (2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; (3) a delineation of the cost and nature of any other services to be provided for an additional fee; (4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; (5) a delineation of the grounds under which the resident may be transferred or have housing or services terminated or be subject to an emergency relocation; (6) billing and payment procedures and requirements; and	0 920		

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0 920	Continued From page 17 (7) disclosure of the facility's ability to provide specialized diets. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to execute a written contract with the required content for two of two residents (R1, R2). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted on May 27, 2025, with diagnosis that included Picks disease (a specific type of dementia). On May 6, 2026, at 7:24 a.m., the surveyor observed owner/unlicensed personnel (O/ULP)-D administer R1's morning medications. R1's service plan dated May 27, 2025, indicated R1 received services to include assistance with hair care, grooming, toileting, bathing, stand by assistance, medication reminders, treatment exercises, modified diet, medication administration, laundry, housekeeping, and "I'm ok" check. R2 R2 was admitted on June 2, 2025, with diagnosis	0 920		

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0 920	Continued From page 18 that included diabetes. R2's service plan dated June 2, 2025, indicated R2 received services to include assistance with hair care, grooming, toileting, bathing, stand by assistance, medication reminders, treatment exercises, modified diet, medication administration, laundry, housekeeping, and "I'm ok" check. R1 and R2's Assisted Living Contract were dated May 27, 2025, and June 2, 2025, respectively. The contracts lacked: -a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license. On May 6, 2026, at 8:36 a.m., assistant licensed assisted living director (ALALD)-A and administrator (A)-C stated the facility is not an assisted living facility with dementia care, and a disclosure that it does not hold an assisted living facility with dementia care license is missing. A-C stated that information is on the Uniform Disclosure of Assisted Living Services and Amenities (UDALSA), but not on the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 920		
0 930 SS=C	144G.50 Subd. 2 (d-e; 1-4) Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact	0 930		

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0 930	Continued From page 19 information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to execute a written contract with the required content for two of two residents (R1, R2). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted on May 27, 2025, with diagnosis	0 930		

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0 930	Continued From page 20 that included Picks disease (a specific type of dementia). On May 6, 2026, at 7:24 a.m., the surveyor observed owner/unlicensed personnel (O/ULP)-D administer R1's morning medications. R1's service plan dated May 27, 2025, indicated R1 received services to include assistance with hair care, grooming, toileting, bathing, stand by assistance, medication reminders, treatment exercises, modified diet, medication administration, laundry, housekeeping, and "I'm ok" check. R2 R2 was admitted on June 2, 2025, with diagnosis that included diabetes. R2's service plan dated June 2, 2025, indicated R2 received services to include assistance with hair care, grooming, toileting, bathing, stand by assistance, medication reminders, treatment exercises, modified diet, medication administration, laundry, housekeeping, and "I'm ok" check. R1 and R2's Assisted Living Contract were dated May 27, 2025, and June 2, 2025, respectively. The contracts lacked: -a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. On May 6, 2026, at 8:45 a.m., assistant licensed assisted living director (ALALD)-A and administrator (A)-C stated the contract lacked a description of the facility's complaint resolution	0 930		

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0 930	Continued From page 21 process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 930		
0 940 SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and	0 940		

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0 940	Continued From page 22 (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to execute a written contract with the required content for two of two residents (R1, R2). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted on May 27, 2025, with diagnosis that included Picks disease (a specific type of dementia). On May 6, 2026, at 7:24 a.m., the surveyor observed owner/unlicensed personnel (O/ULP)-D administer R1's morning medications. R1's service plan dated May 27, 2025, indicated R1 received services to include assistance with hair care, grooming, toileting, bathing, stand by	0 940		

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0 940	Continued From page 23 assistance, medication reminders, treatment exercises, modified diet, medication administration, laundry, housekeeping, and "I'm ok" check. R2 R2 was admitted on June 2, 2025, with diagnosis that included diabetes. R2's service plan dated June 2, 2025, indicated R2 received services to include assistance with hair care, grooming, toileting, bathing, stand by assistance, medication reminders, treatment exercises, modified diet, medication administration, laundry, housekeeping, and "I'm ok" check. R1 and R2's Assisted Living Contracts were dated May 27, 2025, and June 2, 2025, respectively. The contracts lacked a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: - whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; and - whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); -whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; -whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of	0 940		

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0 940	Continued From page 24 time that private payment is required; -a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; -a statement that residents may be eligible for assistance with rent through the housing support program; and -a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program. On May 6, 2026, at 8:36 a.m., assistant licensed assisted living director (ALALD)-A and administrator (A)-C stated R1 and R2's contract lacked a description of the facility's policies related to medical assistance waivers and the housing support program under 256I as listed above. The licensee's undated, Assisted Living Contracts policy indicated the contract must include a description of the facility's policies related to medical assistance waivers under 256S and section 256B.49 and the housing support program under 256I. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 940		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter	01290		

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01290	Continued From page 25 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure background studies were affiliated with their health facility identification (HFID) for one of one employee (administrator (A)-C). This had the potential to affect all residents living within the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: A-C was hired on July 1, 2025, to provide direct care services to residents and to provide staff supervision at the facility. A-C works independently within the facility. A-C's record included a background study	01290		

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01290	Continued From page 26 clearance letter dated June 14, 2024, submitted through a separate license of an affiliated company (HFID 1105416). On May 5, 2026, at 2:04 p.m., administrator (A)-C stated A-C was not affiliated with this HFID (40630) prior to today, and should have been. The licensee's undated, Background Studies policy indicated that each facility employee/volunteer or contractor who will provide direct care to residents must have completed background study. The forms will be completed at the time of hire. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01530 SS=D	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. 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	01530		

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01530	Continued From page 27 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 direct care staff received the required two hours of initial training on mental illness and de-escalation topics for one of one employee (administrator (A)-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	01530		

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01530	Continued From page 28 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: A-C was hired on July 1, 2025, to provide direct care services to residents and to provide staff supervision at the facility. A-C employee's record identified A-C had completed 1.25 hours of the two hours required mental health and de-escalation training. On May 6, 2026, at 3:29 p.m., A-C stated A-C's employee file lacked the required 2 hours of mental health and de-escalation training and he would assign the two hours to himself and complete. 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 29 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 observation, interview, and record	01620		

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01620	Continued From page 30 review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident assessment and reassessment, not to exceed 90 calendar days from the last date of the assessment for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 R1 was admitted on May 27, 2025, with diagnosis that included Picks disease (a specific type of dementia). On May 6, 2026, at 7:24 a.m., the surveyor observed owner/unlicensed personnel (O/ULP)-D administer R1's morning medications. R1's most current 90-day nursing assessment was dated August 30, 2025. There have been no further assessments completed. On May 6, 2026, at 10:16 a.m., administrator (A)-C stated R1's assessment was not updated since August 30, 2025, and is out of compliance. The licensee's undated, Nursing Assessment and Reassessment of Residents policy indicated on-going reassessment and monitoring will be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last assessment.	01620		

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01620	Continued From page 31 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced	01650		

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01650	Continued From page 32 by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included the required content for two of two residents (R1, 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 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: R1 R1 was admitted on May 27, 2025, with diagnosis that included Picks disease (a specific type of dementia). On May 6, 2026, at 7:24 a.m., the surveyor observed owner/unlicensed personnel (O/ULP)-D administer R1's morning medications. R1's service plan dated May 27, 2025, indicated R1 received services to include assistance with hair care, grooming, toileting, bathing, stand by assistance, medication reminders, treatment exercises, modified diet, medication administration, laundry, housekeeping, and "I'm ok" check. R2 R2 was admitted on June 2, 2025, with diagnosis that included diabetes. R2's service plan dated June 2, 2025, indicated	01650		

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01650	Continued From page 33 R2 received services to include assistance with hair care, grooming, toileting, bathing, stand by assistance, medication reminders, treatment exercises, modified diet, medication administration, laundry, housekeeping, and "I'm ok" check. R1 and R2's service plan lacked the following required content: - methods of monitoring staff providing home care services On May 6, 2026, at 11:14 a.m., administrator (A)-C stated all service plans did not include the above required content, stating it was missed. The licensee's undated, Service Plan policy indicated the service plan would include: -the schedule and methods of monitoring staff providing home care services No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01650		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's	01730		

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01730	Continued From page 34 assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to include medication set up service in the service plan for the licensee's two residents (R1, R2).	01730		

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01730	Continued From page 35 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 was admitted on May 27, 2025, with diagnosis that included Picks disease (a specific type of dementia). On May 6, 2026, at 7:24 a.m., the surveyor observed owner/unlicensed personnel (O/ULP)-D administer R1's morning medications that were set up in a weekly med-planner. R1's Individualized Medication Management Plan dated August 30, 2025, indicated services included medication administration and set up. R1's record included a medication administration record (MAR) including staff's initials of documented medication administration from May 1, 2026, through May 6, 2026. R1's Service Agreement/Service Plan dated May 27, 2025, did not include medication set up service, as required. R2 R2 was admitted on June 2, 2025, with diagnosis that included diabetes.	01730		

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01730	Continued From page 36 R2's Individualized Medication Management Plan dated June 2, 2025, indicated services included medication administration and set up. R2's record included a medication administration record (MAR) including staff's initials of documented medication administration from May 1, 2026, through May 6, 2026. R2's Service Agreement/Service Plan dated June 2, 2025, did not include medication set up service. On May 6, 2026, at 11:14 a.m., administrator (A)-C stated R1's and R2's service plans did not include medication set up service as required. The licensee's undated, Individualized Medication Management Plan and Record policy indicated the licensee will develop an individualized medication management plan and record based on the nursing assessment and the needs or preferences of the residents. This plan will be developed with the resident and/or resident's representative and this plan will be part of the resident's service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be	01770		

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01770	Continued From page 37 done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup included all the required content for two of two residents (R1, 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: During the entrance conference on May 5, 2026, at 12:12 p.m., assistant licensed assisted living director (ALALD)-A, clinical nurse supervisor (CNS)-B, and administrator (A)-C stated the licensee provided medication management services to the residents. R1 R1 was admitted on May 27, 2025, with diagnosis that included Picks disease (a specific type of dementia). On May 6, 2026, at 7:24 a.m., the surveyor observed owner/unlicensed personnel (O/ULP)-D administer R1's morning medications that were set up in a weekly med-planner. R1's service plan dated May 27, 2025, indicated R1 received services to include assistance with	01770		

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01770	Continued From page 38 medication administration. R1's medication administration record (MAR) dated between May 1, 2026, and May 6, 2026, indicated R1 received the following medications: -rosuvastatin calcium 10 milligrams (mg), one tablet by mouth daily (for cholesterol) -vitamin D 25 micrograms (mcg), one tablet by mouth daily (a vitamin supplement) R2 R2 was admitted on June 2, 2025, with diagnosis that included diabetes. R2's service plan dated June 2, 2025, indicated R2 received services to include assistance with medication administration. R2's medication administration record (MAR) dated between May 1, 2026, and May 6, 2026, indicated R2 received the following medications: -metformin 100 mg, two tablets by mouth twice daily (for diabetes) -atorvastatin 20 mg, one tablet by mouth daily (for cholesterol) R1 and R2's record lacked documentation of the dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup. On May 6, 2026, at 9:26 a.m., CNS-B stated by telephone that she completed medication set up for R1 and R2 on Sundays. CNS-B stated medication set up was not documented, and she was unaware of the requirement. The licensee's undated, Medication Set Up policy indicated the facility (licensee) will set up	01770		

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01770	Continued From page 39 medications for residents as ordered by the physician/prescriber. Medications will be set up using weekly med-planner. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were stored according to the manufacturer's recommendations in the licensee's one medication refrigerator. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On May 5, 2026, at 1:05 p.m., the surveyor	01880		

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01880	Continued From page 40 reviewed the medication refrigerator located in the basement with clinical nurse supervisor (CNS)-B. The refrigerator contained the following medications: -one vial of Lantus insulin -two Lantus injectable pens The temperature of the medication refrigerator could not be obtained by the surveyor as the medication refrigerator did not have a thermometer inside. On May 5, 2026, at 1:15 p.m., CNS-B stated being unaware the medication fridge did not have a thermometer inside and medications should be stored per manufacturer's instruction. The manufacturer guidelines for storing of Lantus vial and injectable pen dated 2026, indicated Lantus must be refrigerated (36°F to 46°F) until first use. Once opened, they can be stored either in the refrigerator or at room temperature (up to 86°F) and must be discarded after 28 days. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug.	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40630	A. BUILDING: _____ B. WING _____	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOSHEN CONCEPT CARE LLC	1352 CALUMET AVENUE WEST SAINT PAUL, MN 55118

(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 41 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were labeled correctly for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 R1 was admitted on May 27, 2025, with diagnosis that included Picks disease (a specific type of dementia). R1's service plan dated May 27, 2025, indicated R1 received assistance with medication administration. On May 6, 2026, at 7:24 a.m., the surveyor observed owner/unlicensed personnel (O/ULP)-D administer R1's morning medications that were set up in a weekly med-planner. The surveyor observed an unidentified bottle of Vitamin D3 25 micrograms (mcg) in the medication cart that O/ULP-D stated they thought it belonged to R1. On May 6, 2026, at 7:34 a.m., the surveyor observed the medication cart with O/ULP-D and observed a box of Albuterol sulfate inhalation solution 0.083% sterile vials without bearing the	01890		

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	40630	A. BUILDING: _____ B. WING _____	05/06/2026

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01890	Continued From page 42 original prescription label with legible information. O/ULP-D stated not knowing for sure who the medication belonged to. On May 6, 2026, at 9:26 a.m., clinical nurse supervisor (CNS)-B stated the medications the licensee stores should have a label on the bottle demonstrating ownership. The licensee's undated, Medication Prescription and Refills policy indicated a current, written prescriber's prescription must be obtained for any medication, including an over-the-counter medication, whenever staff is responsible for setting up the medication, administering the medication or providing other medication management services for a resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02240 SS=C	144G.90 Subdivision 1 Assisted living bill of rights; notification (a) An assisted living facility must provide the resident a written notice of the rights under section 144G.91 before the initiation of services to that resident. The facility shall make all reasonable efforts to provide notice of the rights to the resident in a language the resident can understand. (b) In addition to the text of the assisted living bill of rights in section 144G.91, the notice shall also contain the following statement describing how to file a complaint or report suspected abuse: "If you want to report suspected abuse, neglect, or financial exploitation, you may contact the	02240		

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02240	Continued From page 43 Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about the facility or person providing your services, you may contact the Office of Health Facility Complaints, Minnesota Department of Health. If you would like to request advocacy services, you may contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities." (c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, email address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities. The statement must include the facility's name, address, email, telephone number, and name or title of the person at the facility to whom problems or complaints may be directed. It must also include a statement that the facility will not retaliate because of a complaint. (d) A facility must obtain written acknowledgment from the resident of the resident's receipt of the assisted living bill of rights or shall document why an acknowledgment cannot be obtained. Acknowledgment of receipt shall be retained in the resident's record. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current Minnesota Bill of Rights for Assisted Living Residents was provided and a written acknowledgement was received for two of two residents (R1, R2). This practice resulted in a level one violation (a	02240		

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02240	Continued From page 44 violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 was admitted on May 27, 2025, with diagnosis that included Picks disease (a specific type of dementia). R2 was admitted on June 2, 2025, with diagnosis that included diabetes. R1 and R2's record did not contain written acknowledgement of receipt of the current Assisted Living Bill of Rights (BOR) dated January 1, 2026. On May 6, 2026, at 8:10 a.m., administrator (A)-C stated R1 and R2's BOR signed May 27, 2025, and June 2, 2025, was an older version dated November 8, 2022. A-C stated this version was provided by the consultant hired by the licensee. The licensee's undated, Assisted Living Bill of Rights policy indicated the licensee will provide the resident or the resident's representative with a written copy of the Assisted Living Bill of Rights (BOR). The Assisted Living BOR shall be redistributed to residents following any revisions or modifications. A signed copy of the Assisted Living BOR will be maintained in the clinical record. No further information was provided.	02240		

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02240	Continued From page 45 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02240		
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 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 medications were administered according to policy and accepted standards of practice for one of one owner/unlicensed personnel (O/ULP)-D with medication administration. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted on May 27, 2025, with diagnosis that included Picks disease (a specific type of dementia).	02320		

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02320	Continued From page 46 R1's service plan dated May 27, 2025, indicated R1 received services to include assistance with medication administration. On May 6, 2026, at 7:24 a.m., the surveyor observed O/ULP-D administer R1's morning medications that were set up in a weekly med-planner. O/ULP-D provided medication administration without referring to the electronic medication administration record. R1's provider orders dated February 6, 2026, included: -rosuvastatin calcium 10 milligrams (mg), one tablet by mouth daily (for cholesterol) -Vitamin D 25 micrograms (mcg), one tablet by mouth daily (a vitamin supplement) R1's medication administration record (MAR) dated between May 1, 2026, and May 6, 2026, indicated R1 received the following medications: -rosuvastatin calcium 10 mg, one tablet by mouth daily (for cholesterol) -Vitamin D 25 mcg, one tablet by mouth daily (a vitamin supplement) On May 6, 2026, at 9:33 a.m., clinical nurse supervisor (CNS)-B stated O/ULP-C was trained to refer to the electronic MAR prior to giving medication, and following the six rights. The licensee's undated, Documentation of Medication Administration policy indicated staff locate appropriate medication administration record for the client. Staff will also refer to the medication profile listing the medication name, strength, description, amount to be given and time of day to be given, as well as the purpose of the medication and any special instructions, if applicable.	02320		

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02320	Continued From page 47 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

Goshen Concept Care LLC
1352 CALUMET AVENUE
West St Paul, MN 55118
Dakota County
Parcel:

Phone:
info@goshenconceptcare.com

License Info

License: HFID 40630

Risk:
License:
Expires on:
CFPM: Samlina Cawray
CFPM #: 23617; Exp: 4/16/2029

Inspection Info

Report Number: F1031261167
Inspection Type: Full - Single
Date: 5/5/2026 Time: 10am
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

Nurse Evaluator on site: Jenn Panitzke

All violations discussed with PIC during the inspection.

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

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

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

NOTE: 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 F1031261167 from 5/5/2026

Hope Abedayo
Person in Charge

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

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

Temperature Observations/Recordings

Establishment Info

Goshen Concept Care LLC
West St Paul
County/Group: Dakota County

Inspection Info

Report Number: F1031261167
Inspection Type: Full
Date: 5/5/2026
Time: 10am

Food Temperature: Product/Item/Unit: Milk**; Temperature Process:** Cold-Holding
Location: Refrigerator at 41 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

Goshen Concept Care LLC
West St Paul
County/Group: Dakota County

Inspection Info

Report Number: F1031261167
Inspection Type: Full
Date: 5/5/2026
Time: 10am

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

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

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL40630015-0	**Date:** May 6, 2026
Facility Name: GOSHEN CONCEPT CARE LLC	
Facility Address: 1352 CALUMET AVE, W ST. PAUL, MN 55118	

☒ **TAG IDENTIFICATION: 0780**

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

1. Smoke Alarm power supply complies with MN State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated. [Minn. Stat. 144G.45 subd.2]

   Comments: The existing hardwired smoke alarms were removed from the upper level bedroom hallway and replaced with battery powered smoke alarms. Existing hardwired smoke alarms are required to be maintained as installed previously and shall be replaced with smoke alarms having the same type of power supply.

☒ **TAG IDENTIFICATION: 0800**

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

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

   Comments: The facility had a basement bathroom with a shower located in the utility room under the stairs. The bathroom ceiling seams were warped, and tape was being used to hold it together. The area had a mold-like substance on the walls. The floors were dirty, and the area was not being maintained for resident use. Administrator (A)-C stated that the bathroom wasn't used and was there when the house was purchased. The bathroom must be cleaned and maintained in good repair to prevent water and moisture from getting into the walls.

DEPARTMENT OF HEALTH

In the upper level bathroom, the caulk/sealant along the walls of the shower was cracked and beginning to peel.

☒ **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 that include employee actions to be taken in the event of a fire or similar emergency. [Minn. Stat. 144G.45 subd.2]

   Comments: The FSEP failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate).

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: The FSEP did not identify specific fire protection actions for residents. There was no section in the plan that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency.

3. 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: Administrator (A)-C lacked documentation showing training was completed twice in 2025 for staff on the fire safety and evacuation plan. A-C provided staff training records from a web-based training site, the training documentation record lacked any training on the facility specific fire safety and evacuation plan.

4. 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: A-C lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan.