



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF INITIAL LICENSE DENIAL

Electronically Delivered

September 29, 2026

Licensee
Golden Haven LLC
16154 Estate Lane
Antlers Park, MN 55044

RE: Denial of License Number 420711
Health Facility Identification Number (HFID) 41716
Initial survey; Project Number(s) SL41716015

Dear Licensee:

The Minnesota Department of Health (MDH) completed an initial survey on September 3, 2026 for the purpose of assessing compliance with state licensing statutes and determine issuance of an initial license to the above-mentioned provider. Based on the survey, MDH found you not in substantial compliance with the laws pursuant to Minnesota Statute, Chapter 144G. As a result, your authority to continue to operate under a provisional license or be approved for an assisted living facility license is being denied.

INELIGIBLE LICENSURE TIMELINE

Pursuant to Minn. Stat. § 144G.16, subd. 3 (c), the owners and managerial officials of a provisional licensee whose license is denied are ineligible to apply for an assisted living facility license under this chapter for one (1) year following the facility's closure date.

STATE CORRECTION ORDERS

The enclosed State Form documents the state licensing orders. The Department of Health documents state 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 . . ."

REQUEST FOR RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.16, Subd. 4, you may request a reconsideration by the Minnesota Department of Health. The request for reconsideration process must be conducted internally by the Minnesota Department of Health and Chapter 14 does not apply. **This is your only ability to request a reconsideration under this enforcement action.**

To submit a reconsideration request, please visit:

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

Note requests for reconsideration must be received by the department within 15 calendar days of the date of this notice.

REQUIREMENTS FOR NOTIFICATION AND TRANSFER OF RESIDENTS

You must comply with the requirements for notification and coordinated move of residents noted in Minn. Stat. § 144G.52 and Minn. Stat. § 144G.55. Additionally, please provide the information described in Minn. Stat. § 144G.20, Subd. 15 (a) (1), (2), (3), (4) and (5) to this department's contact, Jodi Johnson, via email at: Jodi.Johnson@state.mn.us. Also provide this information to the lead agencies as defined in section 256B.0911, county adult protection and case managers, and the ombudsman for long-term care **no later than October 2, 2026**.

Pursuant to Minn. Stat. § 144G.16, Subd. 5 (3), a provisional licensee whose license is denied is permitted to continue operating as an assisted living facility during the period of time when a transfer of assisted living facility resident(s) from the provisional licensee to a new assisted living facility provider is in process.

Additionally, pursuant to Minn. Stat. § 144G.16, Subd. 5 (1), you may continue operating during the reconsideration process.

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.

If you have any additional questions, please do not hesitate to contact Jodi Johnson, Supervisor, at Jodi.Johnson@state.mn.us. Jodi Johnson can also be reached by office phone at 507-344-2730.

Sincerely,



Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41716	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/03/2026
NAME OF PROVIDER OR SUPPLIER GOLDEN HAVEN LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 16154 ESTATE LANE ANTLERS PARK, MN 55044			
(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: SL41716015-0 On August 31, 2026, through September 3, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were three residents; three receiving services under the Provisional Assisted Living Facility license. 0470: An immediate order was issued on September 1, 2026, at a level 3/Widespread. The licensee took immediate action, but the scope and level remain at I.	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.		
0 330 SS=D	144G.30 Subd. 4 Information provided by facility (a) The assisted living facility shall provide	0 330			

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 330	Continued From page 1 accurate and truthful information to the department during a survey, investigation, or other licensing activities. (b) Upon request of a surveyor, assisted living facilities shall within a reasonable period of time provide a list of current and past residents and their legal representatives and designated representatives that includes addresses and telephone numbers and any other information requested about the services to residents. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide the Minnesota Department of Health (MDH) with accurate and truthful information during a survey. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R4 R4 was admitted and started receiving services on July 23, 2026, with diagnoses including bipolar disorder. R4's Master Care Plan last updated August 14, 2026, indicated R4 received services including assistance with medication administration, behavior management, meals, transportation,	0 330			

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0 330	Continued From page 2 arranging appointments, housekeeping, and laundry. The care plan further indicated R4 was independent with no assistance required with bathing and grooming. The care plan further indicated R4 had no history of wandering. R4's Service Recap Summary dated August 2026, indicated staff assisted R4 with bathing and grooming, and managing wandering. On September 2, 2026, at 12:11 p.m., owner (O)-A stated R4 at times required assistance getting in and out of bed if her hip and back were bothering her; otherwise R4 was independent with bathing, grooming, and dressing. O-A further stated R4 did not have issues with wandering. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 330			
0 470 SS=I	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	0 470			

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0 470	Continued From page 3 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: Based on observation, interview, and record review, the licensee failed to ensure that one or more awake staff were available in the assisted living, 24 hours per day, seven days per week, to be responsible for responding to the requests of residents for assistance with health or safety needs and in accordance with MN Rules 4659.0180. This had the potential to affect all residents at the facility and resulted in an immediate correction order on September 1, 2026. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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:	0 470			

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0 470	Continued From page 4 The licensee's Staffing Plan reviewed May 14, 2026, indicated: At least one qualified staff member is awake and on-site at all times to provide supervision, respond to resident needs, and manage emergencies. The facility operates two twelve-hour shifts to provide continuous coverage: Day Shift (7:00 AM - 7:00 PM) and Night Shift (7:00 PM - 7:00 AM). Staffing assignments are adjusted whenever resident needs or census change. The posted Weekly Staff Schedule provided for the week of survey (August 31, 2026 - September 6, 2026), indicated one staff person was scheduled for the 7:00 PM - 7:00 AM shift. On August 31, 2026, at 1:20 p.m., surveyors arrived at the facility and were let into the residence by R3. R3 stated the staff member that was working was upstairs and stated he would let her know the surveyors had arrived. When R3 returned to the main level he stated the staff member needed to use the bathroom then would come down. A couple of minutes later, unlicensed personnel (ULP)-E came down the stairs and the surveyors introduced themselves and announced the survey. ULP-E stated she would call owner (O)-A and let him know of the surveyors arrival. The surveyors requested that ULP-E give them a tour of the facility while they waited for O-A to arrive. When ULP-E brought the surveyors to the upper level of the residence, they observed a bedroom at the top of the stairs on the right with a number four (4) on the door. In the far corner of the room against the wall, was a mattress with a top sheet on it, two pillows, and a comforter that was crumpled at the end of the bed. There was a covered to-go drink from a restaurant that was two thirds full on the floor next to the mattress. The drink had a label on it from	0 470			

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0 470	Continued From page 5 the restaurant, indicating the contents of the beverage, and dated August 31, 2026, with a time of 7:24 a.m. ULP-E stated the bedroom was utilized by the night staff. The surveyor asked ULP-E if the night staff slept in the bedroom and she stated not knowing because she never worked the night shift. On September 1, 2026, at 8:17 a.m., R1 stated sometimes the staff will use the bedroom at the top of the stairs with the mattress on the floor to sleep in. R1 further stated if you needed something while they were in there sleeping, you had to wake them up. On September 1, 2026, at 9:25 a.m., R4 stated sometimes the staff will use the bedroom upstairs with the mattress on the floor to sleep. The surveyor asked R4 if she ever had to wake staff up during the night if she needed anything. R4 denied needing to awaken staff as once she takes her medications, she sleeps through the night. On September 1, 2026, at 12:30 p.m., the surveyor interviewed O-A, licensed assisted living director (LALD)-B, and house manger (HM)-D. O-A stated one staff was routinely scheduled to work the overnight shift (7:00 PM - 7:00 AM). The surveyor asked if the overnight staff slept during their shift and all three denied this was happening. When asked how they knew for sure, HM-D stated because staff knew they were supposed to stay awake. The surveyor asked why there was a mattress with bedding on it in room 4, and they denied knowledge that there was a mattress in the room. The surveyor then asked the staff to accompany her to room 4. The mattress and all the bedding had been removed from the room. The surveyor brought up the	0 470			

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0 470	Continued From page 6 pictures that had been taken from the day before. HM-D stated sometimes they would keep a mattress in the unoccupied rooms to get them ready for a new resident or to store other items. All three again denied knowledge that the mattress had been in the room and did not know who had removed it. The licensee's Staffing policy effective November 13, 2025, indicted: The Clinical Nurse Supervisor will prepare and implement a 24-hours daily staffing plan that ensures adequate staffing to meet residents' needs at all times, including reasonably foreseeable needs. No further information provided. TIME PERIOD FOR CORRECTION: Immediate On September 3, 2026, the immediacy of correction order 0470 has been removed as confirmed by review by evaluation supervisor; however, the scope and level remains at I.	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 CFPM is present at each facility frequently	0 480			

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0 480	Continued From page 7 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 8 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated September 1, 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			
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that	0 580			

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0 580	Continued From page 9 have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in and maintain documentation of ongoing quality management activities relevant to the size and services provided by the assisted living provider. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on August 31, 2026, at 2:03 p.m., the surveyor requested the licensee's quality management plan and meeting minutes. Licensed assisted living director (LALD)-B stated the licensee had not been conducting quality management meetings, nor did they have a current quality project they were working on.	0 580			

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0 580	Continued From page 10 The licensee's Quality Improvement policy effective November 13, 2025, indicated: [Licensee name] has established a quality improvement program based on the organization's size and appropriate to the type of services provided in order to assure that effective, comprehensive and appropriate plans are operational for all residents within the organization. The medication management program is an integral part of the overall quality improvement program. The quality improvement program assists the organization in focusing on key activities to maintain quality resident care and effective utilization of services and resources. [Licensee name] intends to improve systems and build quality into all processes in order to meet or exceed resident expectations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580			
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.	0 630			

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0 630	Continued From page 11 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 the required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted and started receiving services on January 6, 2026, with diagnoses including paranoid schizophrenia and antisocial personality disorder. R1's Service Plan dated May 9, 2026, indicated R1 received services including assistance with dressing, grooming, bathing, medication administration, money management, behavior management, meals, transportation, arranging appointments, housekeeping, and laundry. R1's Individual Abuse Prevention Plan (IAPP) June 30, 2026, failed to include: -whether the person was at risk of abusing other vulnerable adults. On September 1, 2026, at 11:13 a.m., clinical nurse supervisor (CNS)-C reviewed R1's IAPP and stated it did not included the above required content.	0 630			

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NAME OF PROVIDER OR SUPPLIER GOLDEN HAVEN LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 16154 ESTATE LANE ANTLERS PARK, MN 55044			
(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
0 630	Continued From page 12 The licensee's Vulnerable Adult Policy effective November 13, 2025, indicated: 2d. An individual abuse prevention plan shall be established for each vulnerable minor or adult for whom assisted living services are provided. 2) The plan shall contain the resident's risk of abusing other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			
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	0 730			

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0 730	Continued From page 13 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 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 interview and record review, the licensee failed to ensure the resident record included the required documentation of all provided services for all three current residents (R1, R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to	0 730			

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0 730	Continued From page 14 affect a large portion or all of the residents). The findings include: R1 R1 was admitted and started receiving services on January 6, 2026, with diagnoses including paranoid schizophrenia and antisocial personality disorder. R1's Service Plan dated May 9, 2026, indicated R1 received services including assistance with dressing, grooming, bathing, medication administration, money management, behavior management, meals, transportation, arranging appointments, housekeeping, and laundry. R1's medication administration record (MAR) dated January 2026, indicated R1 began receiving medication administration services the evening of January 6, 2026. R1's Service Recap Summary dated January 2026, indicated documentation of all services received that were included in the service plan. There was no documentation of any services received other than medication administration until the evening of January 10, 2026. R3 R3 was admitted and started receiving services on April 20, 2026, with diagnoses including major depression, high blood pressure, and chronic knee pain. R3's Service Plan dated April 25, 2026, indicated R3 received services including assistance with dressing, medication administration, money management, behavior management, meals, transportation, arranging appointments,	0 730			

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0 730	Continued From page 15 housekeeping, and laundry. R3's MAR dated April 2026, indicated R3 began receiving medication administration services the evening of April 21, 2026. R3's Service Recap Summary dated April 2026, indicated documentation of all services received that were included in the service plan. There was no documentation of any services received other than medication administration until the evening of April 28, 2026. R4 R4 was admitted and started receiving services on July 23, 2026, with diagnoses including bipolar disorder. R4's Master Care Plan last updated August 14, 2026, indicated R4 received services including assistance with medication administration, behavior management, meals, transportation, arranging appointments, housekeeping, and laundry. R4's MAR dated July 2026, indicated R4 began receiving medication administration services the morning of July 24, 2026. R4's Service Recap Summary dated August 2026, indicated documentation of all services received that were part of the care plan. There was no documentation of any services received other than medication administration until the evening of August 14, 2026. In addition, there was no documentation of these services for the month of July 2026, after R4 had been admitted to the licensee. On September 3, 2026, at 12:19 p.m., licensed	0 730			

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0 730	Continued From page 16 assisted living director (LALD)-A was unable to locate evidence of documentation of R1, R3, and R4's missing services. LALD-A stated they had not been utilizing written documentation prior to inputting the services into the electronic record. In addition, LALD-A stated their were no progress notes written since admission for R4. The licensee's Clinical Records policy effective November 13, 2025, indicated: 6. The clinical contains the following information: - Documentation of communication/coordination pertinent to the resident's assisted living services - Documentation of services provided as identified in the service plan No further information was provided. TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days	0 730			
0 775 SS=E	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 two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 775			

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0 775	Continued From page 17 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated Septmeber 1, 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=C	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	0 800			

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0 800	Continued From page 18 Statute 144G. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated September 1, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	0 800			
01610 SS=F	144G.70 Subd. 2 (a-b) 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 the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods	01610			

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01610	Continued From page 19 based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted an initial assessment for three of three new residents (R1, R3, R4) prior to initiation of services. 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 started receiving services on January 6, 2026, with diagnoses including paranoid schizophrenia, major depressive disorder, antisocial personality disorder, asthma, and high blood pressure. R1's Service Plan dated May 9, 2026, indicated R1 received services including assistance with dressing, grooming, bathing, medication administration, money management, behavior management, meals, transportation, arranging appointments, housekeeping, and laundry. R1's Admission Assessment was completed by the RN on January 11, 2026, (five days after start of services).	01610			

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01610	Continued From page 20 R3 R3 started receiving services on April 20, 2026, with diagnoses including major depression, high blood pressure, and chronic knee pain. R3's Service Plan dated April 25, 2026, indicated R3 received services including assistance with dressing, medication administration, money management, behavior management, meals, transportation, arranging appointments, housekeeping, and laundry. R3's Admission Assessment was completed by the RN on April 24, 2026, (four days after start of services). R4 R4 started receiving services on July 23, 2026, with diagnoses including bipolar disorder. R4's Master Care Plan last updated August 14, 2026, indicated R4 received services including assistance with medication administration, behavior management, meals, transportation, arranging appointments, housekeeping, and laundry. R4's Admission Assessment was completed by the RN on July 27, 2026, (four days after start of services). There was a note on the assessment that indicated: Pt (patient) refused to complete assessment on initial day. On September 3, 2026, at 12:19 p.m., clinical nurse supervisor (CNS)-C reviewed R1 and R3's initial assessments that had been completed by the previous CNS, and stated they had been completed late. CNS-C stated R4 had refused to participate in her initial assessment on the day of	01610			

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01610	Continued From page 21 admission as R4 had "other plans." CNS-C further stated R4 wanted to wait until July 27, 2026, to complete the assessment. R4's record further lacked any progress notes since admission. The licensee's Assessment and Reassessment policy effective November 13, 2025, indicated: 2. The initial RN assessment shall be completed prior to the date on which the prospective resident executes a contract or on the date on which the prospective resident moves in, whichever is earlier. If necessary, based on geography or urgent or unexpected circumstances, the assessment may be conducted via telecommunications based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01610			
01620 SS=F	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	01620			

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01620	Continued From page 22 distance between the prospective resident and 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:	01620			

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01620	Continued From page 23 Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a resident assessment within 14 days of admission for all three current residents (R1, R3, R4), and ongoing resident assessments that did not exceed 90 days for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 started receiving services on January 6, 2026, with diagnoses including paranoid schizophrenia, major depressive disorder, antisocial personality disorder, asthma, and high blood pressure. R1's Service Plan dated May 9, 2026, indicated R1 received services including assistance with dressing, grooming, bathing, medication administration, money management, behavior management, meals, transportation, arranging appointments, housekeeping, and laundry. R1's 14-day assessment was completed by the RN on January 26, 2026, 20 days after start of services (six days late). R1's 90-day assessment was completed on June 1, 2026, 126 days after the 14-day assessment (36 days late).	01620			

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01620	Continued From page 24 R3 R3 started receiving services on April 20, 2026, with diagnoses including major depression, high blood pressure, and chronic knee pain. R3's Service Plan dated April 25, 2026, indicated R3 received services including assistance with dressing, medication administration, money management, behavior management, meals, transportation, arranging appointments, housekeeping, and laundry. R3's 14-day assessment was completed by the RN on May 4, 2026, 17 days after start of services (three days late). R4 R4 started receiving services on July 23, 2026, with diagnoses including bipolar disorder. R4's Master Care Plan last updated August 14, 2026, indicated R4 received services including assistance with medication administration, behavior management, meals, transportation, arranging appointments, housekeeping, and laundry. R4's 14-day assessment was completed by the RN on August 14, 2026, 22 days after start of services (eight days late). On September 3, 2026, at 12:19 p.m., clinical nurse supervisor (CNS)-C reviewed R1's 14 and 90-day assessments and R3's 14-day assessment that had been completed by the previous CNS, and stated they had been completed late. CNS-C reviewed R4's 14-day assessment and stated it was completed late. The licensee's Assessment and Reassessment	01620			

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01620	Continued From page 25 policy effective November 13, 2025, indicated: 7. The RN will provide a reassessment visit to update the evaluation of the resident and services no more than 14 days after initiation of services. 8. Ongoing resident reassessments must be conducted by an RN and cannot exceed 90 days from the last date of assessment. No further information 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	01650			

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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
01650	Continued From page 26 (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure all three current residents' (R1, R3, R4) service plans included all the required content. In addition, the licensee failed to finalize a service plan within 14 days after start of services for one of three residents (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 began receiving services on January 6, 2026. R1's Service Plan dated May 9, 2026, indicated R1 received services including assistance with dressing, grooming, bathing, medication administration, money management, behavior management, meals, transportation, arranging appointments, housekeeping, and laundry. On September 1, 2026, at 8:03 a.m., the surveyor observed unlicensed personnel (ULP)-E	01650			

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01650	Continued From page 27 administering medications to R1. R3 R3 began receiving services on April 20, 2026. R3's Service Plan dated April 25, 2026, indicated R3 received services including assistance with dressing, medication administration, money management, behavior management, meals, transportation, arranging appointments, housekeeping, and laundry. R1 and R3's Service Plan lacked the following: - the schedule and methods of monitoring staff providing services R4 R4 was admitted and started receiving services on July 23, 2026, with diagnoses including bipolar disorder. On September 2, 2026, at 8:15 a.m., owner (O)-A stated R4 did not have a signed service plan yet; they were utilizing R4's Master Care Plan as her service plan. R4's Master Care Plan last updated August 14, 2026, indicated R4 received services including assistance with medication administration, behavior management, meals, transportation, arranging appointments, housekeeping, and laundry. On September 1, 2026, at 9:23 a.m., the surveyor observed ULP-E administering medications to R4. R4's Master Care Plan (service plan) lacked the following: - the fees for services, and the frequency of each	01650			

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01650	Continued From page 28 service, according to the resident's current assessment and resident preferences; - the schedule and methods of monitoring assessments of the resident; - the schedule and methods of monitoring staff providing services; and - a contingency plan that includes: - action to be taken if the scheduled service cannot be provided; - information and a method to contact the facility; - the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and - the circumstances in which emergency medical services are not go be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. On September 3, 2026, at 12:19 p.m., licensed assisted living director (LALD)-A reviewed R1, R3, and R4's service plans and stated they were missing the required content. The licensee's Service Plan policy effective November 13, 2025, indicated: 2. The service plan will be finalized no later than 14 days after the date home care services are first provided, if not already completed. 8. The service plan includes the following: a. A description of the services to be provided; the service description may be in the form of the resident's care plan and developed with the resident/responsible party b. The fees for services and the frequency of	01650			

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01650	Continued From page 29 each service, according to the resident's current review or assessment and the resident preferences c. The identification of the staff or categories of staff who will provide the services d. The schedule and methods of monitoring reviews or assessments of the resident The second page of the policy was not available. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01650			
01700 SS=F	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to	01700			

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01700	Continued From page 30 manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management assessment to include all required content for one of one resident (R1), prior to providing medication management services. 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: During the entrance conference on August 31, 2026, at 2:03 p.m., clinical nurse supervisor (CNS)-C stated the licensee provided medication management services to all three residents receiving assisted living services. R1 R1 started receiving services on January 6, 2026, with diagnoses including paranoid schizophrenia, major depressive disorder, antisocial personality disorder, asthma, and high blood pressure.	01700			

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01700	Continued From page 31 R1's Service Plan dated May 9, 2026, indicated R1 received services including assistance with medication administration. R1's medication administration record (MAR) dated January 2026, indicated R1 began receiving medication administration services the evening of January 6, 2026. The MAR included one non-steroidal anti-inflammatory, two supplements, two antipsychotics, two for high blood pressure, one diuretic (water pill), one proton-pump inhibitor (to lower stomach acid), one for constipation, one for high cholesterol, and one for enlarged prostate. R1's Admission Assessment (including assessment of medications) was completed by the RN on January 11, 2026, (five days after start of medication administration services). The assessment did not identify interventions needed in the management of medications to prevent diversion of medications by the resident or others who may have access to the medications. R3 R3 started receiving services on April 20, 2026, with diagnoses including major depression, high blood pressure, and chronic knee pain. R3's Service Plan dated April 25, 2026, indicated R3 received services including assistance medication administration. R3's MAR dated April 2026, indicated R3 began receiving medication administration services the evening of April 21, 2026. The MAR included one antidepressant, and two medications to treat high blood pressure. R3's Admission Assessment (including	01700			

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01700	Continued From page 32 assessment of medications) was completed by the RN on April 24, 2026, (three days after start of medication administration services). The assessment did not identify interventions needed in the management of medications to prevent diversion of medications by the resident or others who may have access to the medications. R4 R4 started receiving services on July 23, 2026, with diagnoses including bipolar disorder. R4's Master Care Plan last updated August 14, 2026, indicated R4 received services including assistance with medication administration. R4's MAR dated July 2026, indicated R4 began receiving medication administration services the morning of July 24, 2026. The MAR included two antidepressants, one antipsychotic, one medication to treat high blood pressure, One mood stabilizer, two supplements, and one anticholinergic (used to treat extrapyramidal {relating to the nerve tracts and brain structures outside the pyramidal tracts that help control involuntary movements, muscle tone, and posture} side effects caused by antipsychotic drugs). R4's Admission Assessment (including assessment of medications) was completed by the RN on July 27, 2026, (three days after start of medication administration services). The assessment did not identify interventions needed in the management of medications to prevent diversion of medications by the resident or others who may have access to the medications. On September 1, 2026, at 11:13 a.m., clinical nurse supervisor (CNS)-C reviewed R1's	01700			

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01700	Continued From page 33 admission/medication assessment and stated it did not include interventions to prevent diversion and was unaware of the requirement. On September 3, 2026, at 12:19 p.m., CNS-C reviewed R1, R3, and R4's admission/medication assessments and stated they had not been completed prior to providing medication administration services to all three residents. The licensee's Assessment of Medications policy dated November 13, 2025, indicated: Prior to providing medication management services, [Licensee name] will provide an assessment by a registered nurse (RN) to determine what medication management services will be provided and how they will be implemented. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700			
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided;	01730			

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01730	Continued From page 34 (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 interview and record review, the licensee failed to develop an individualized medication management record with the required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01730			

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01730	Continued From page 35 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: During the entrance conference on August 31, 2026, at 2:03 p.m., clinical nurse supervisor (CNS)-C stated the licensee provided medication management services to the licensee's residents. On September 1, 2026, at 8:03 a.m., the surveyor observed unlicensed personnel (ULP)-E administering medications to R1. R1 started receiving services on January 6, 2026, with diagnoses including paranoid schizophrenia, major depressive disorder, antisocial personality disorder, asthma, and high blood pressure. R1's Service Plan dated May 9, 2026, indicated R1 received services including assistance with medication administration. R1's medication administration record (MAR) dated January 2026, indicated R1 began receiving medication administration services the evening of January 6, 2026. The MAR included one non-steroidal anti-inflammatory, two supplements, two antipsychotics, two for high blood pressure, one diuretic (water pill), one proton-pump inhibitor (to lower stomach acid), one for constipation, one for high cholesterol, and one for enlarged prostate. R1's individual medication management plan	01730			

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01730	Continued From page 36 lacked: -a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; On September 1, 2026, at 11:13 a.m. clinical nurse supervisor (CNS)-C reviewed R1's medication management plan and stated it did not included the above content. The licensee's Assessment of Medications policy effective November 13, 2025, indicated: 2f. Based on the results of the assessment, the RN (registered nurse) will document an individualized medication management plan, including the following elements ii. Description of medication storage based on resident need, preference, risk of diversion and per manufacturer's direction No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
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	01760			

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01760	Continued From page 37 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 ensure medications were administered as ordered for one of two residents (R4), and failed to transcribe all medication orders accurately for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R4 R4 started receiving services on July 23, 2026, with diagnoses including bipolar disorder. R4's Master Care Plan last updated August 14, 2026, indicated R4 received services including assistance with medication administration. On September 1, 2026, at 9:23 a.m., the surveyor observed unlicensed personnel (ULP)-E setting up R4's medications for administration. R4 stated to ULP-E that she would also like her "Tylenol" for hip pain. ULP-E obtained a blister pack medication card from R4's PRN (as needed)	01760			

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01760	Continued From page 38 medication bin; the prescription label included R4's name and the following prescription: acetaminophen 500 mg (milligrams) by mouth every four hours as needed for pain. The surveyor asked ULP-E to show her the order in R4's electronic administration record (eMAR). ULP-E stated the nurse had not put the order into the computer yet, but she was "working on it". ULP-E stated she would make a progress note that the acetaminophen had been administered to R4. ULP-E then proceeded to administer R4 her morning medications including the PRN acetaminophen. R4's medical record did not include a prescriber order for the PRN acetaminophen On September 1, 2026, at 11:13 a.m., clinical nurse supervisor (CNS)-C stated R4 had brought the PRN acetaminophen medication with her from her previous placement; however, she did not think there was a current order to administer the acetaminophen. CNS-C called the pharmacy and stated they were unable to locate a current prescriber order for R4's PRN acetaminophen. On September 3, 2026, at 10:33 a.m., the surveyor emailed the licensee requesting all of R4's progress notes since admission. At 11:05 a.m., LALD-B stated they had no progress notes for R4. The surveyor asked if staff had documented any notes on R4 elsewhere. LALD-A stated only through text messages, but nothing in the electronic record. There was no documentation of ULP-E administering R4's PRN acetaminophen on September 1, 2026. R1 R1 started receiving services on January 6, 2026, with diagnoses including paranoid schizophrenia	01760			

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01760	Continued From page 39 and antisocial personality disorder. R1's Service Plan dated May 9, 2026, indicated R1 received services including assistance with medication administration. R1's After Visit Summary dated June 18, 2026, included the following orders: - aspirin 81 mg (milligrams) chewable tablet. Take one tablet (81 mg) by mouth daily. - trazodone 100 mg tablet. Take one tablet (100 mg) by mouth at bedtime. R1's MAR dated September 2026, included the following orders: - aspirin and dipyridamole 81 mg chew and swallow one tablet by mouth daily - trazodone hydrochloride 100 mg take 1/2 (one-half) tablet by mouth every night - trazodone (no dosage indicated) take 1/2 tablet by mouth at bedtime as needed On September 2, 2026, at 11:10 a.m., the surveyor emailed the licensee requesting verification of the above orders that were on R1's MAR. On September 2, 2026, at 12:45 p.m., licensed assisted living director (LALD)-A stated he had spoken with CNS-C who stated the aspirin and dipyridamole order and the trazodone orders that they surveyor was requesting, were "old" orders, and the orders in the chart were the current orders. The surveyor and LALD-B observed the medication cabinet. R1's trazodone set up by the pharmacy was trazodone 100 mg at bedtime and the aspirin 81 mg chewable tablet was set up for AM; it did not include dipyridamole. In R1's PRN medication bin were two blister packs for the previous orders for trazodone 100 mg ½ tablet at	01760			

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01760	Continued From page 40 bedtime and ½ tablet daily as needed. On September 2, 2026, at 1:11 p.m., CNS-C stated when she tried to input R1's aspirin order into the software, the choice she was given was for aspirin and dipyridamole so that's what she inputted. For the trazodone order, CNS-C stated she must have transcribed the order wrong as R1 is supposed to be getting 100 mg (one full tab) at bedtime. CNS-C stated there was no current order for the PRN trazodone; she kept it on the MAR as was going to check with R1's provider at the next appointment to see if they wanted to add it back in. CNS-C stated they haven't been giving the PRN trazodone and it wasn't in his PRN medication bin. The surveyor informed CNS-C that the PRN trazodone was in R1's PRN medication bin and was accessible to the ULPs to administer if requested. The licensee's Prescriber's Orders policy effective November 13, 2025, indicated: 1. Written orders from an authorized prescriber will be obtained for all medications and treatments with which the assisted living facility assists residents, including over the counter medications. The licensee's Medication Documentation policy effective November 13, 2025, indicated: Each medication administered by [Licensee name] staff will be documented in the resident's clinical record. 5. For PRN medications, documentation will include, when appropriate, the reason for the medication and follow-up to determine its effectiveness. The licensee's Medication Administration policy effective November 13, 2025, indicated:	01760			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER GOLDEN HAVEN LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 16154 ESTATE LANE ANTLERS PARK, MN 55044			
(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 41 7. The licensed nurse is responsible for assessing medications to assure that all medications are current and ordered by the prescriber and to identify any expired or outdated medications, which will be disposed according to policy. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01760			
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel,	01790			

Minnesota Department of Health

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01790	Continued From page 42 including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) developed training and competencies for two of two unlicensed personnel (ULP-C, ULP-D)	01790			

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01790	Continued From page 43 providing medications for residents with unplanned time away from home when the licensed nurse was not available. 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 included: ULP-E and ULP-F were hired to provide direct care services to the licensee's residents on January 29, 2026. ULP-E and ULP-F's employee record lacked documentation of competencies for providing medications to residents with medication management who have unplanned time away from home. On September 2, 2026, at 1:43 p.m., licensed assisted living director (LALD)-A stated the licensee did not have a training/competency on unplanned time away for medications, although the ULPs have provided this service to the residents. The licensee's Medication Management Plan for Residents Away from Home policy effective November 13, 2025, indicated: 2. For unplanned times away from home for temporary periods when an adequate medication supply cannot be obtained from the pharmacy or set up by the registered nurse in a timely manner,	01790			

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01790	Continued From page 44 the registered nurse may delegate to an unlicensed personnel (home health aide) to provide the medications based on the following a. The RN (registered nurse) has trained the home health aide (ULP) and determined the home health aide competency to follow procedures for giving medications to residents b. The registered nurse has instructed the home health aide (ULP) to ensure that all appropriate precautions are taken. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790			
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a current written or electronically recorded prescription was obtained for all medications the provider had managed for one of two residents (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or	01820			

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01820	Continued From page 45 a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R4 started receiving services on July 23, 2026, with diagnoses including bipolar disorder. R4's Master Care Plan last updated August 14, 2026, indicated R4 received services including assistance with medication administration. On September 1, 2026, at 9:23 a.m., the surveyor observed unlicensed personnel (ULP)-E setting up R4's medications for administration. R4 stated to ULP-E that she would also like her "Tylenol" for hip pain. ULP-E obtained a blister pack medication card from R4's PRN (as needed) medication bin. The prescription label included R4's name and the following prescription: acetaminophen 500 mg (milligrams) by mouth every four hours as needed for pain. The surveyor asked ULP-E to show her the order in R4's electronic administration record (eMAR). ULP-E stated the nurse had not put the order into the computer yet, but she was "working on it". ULP-E stated she would make a progress note that the acetaminophen had been administered to R4. ULP-E then proceeded to administer R4 her morning medications including the PRN acetaminophen. R4's medical record did not include a prescriber order for the PRN acetaminophen. On September 1, 2026, at 11:13 a.m., clinical nurse supervisor (CNS)-C stated R4 had brought the PRN acetaminophen medication with her from her previous placement; however, she did not think there was a current order to administer	01820			

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01820	Continued From page 46 the acetaminophen. CNS-C called the pharmacy and stated they were unable to locate a current prescriber order for R4's PRN acetaminophen. The licensee's Prescriber's Orders policy effective November 13, 2025, indicated: 1. Written orders from an authorized prescriber will be obtained for all medications and treatments with which the assisted living facility assists residents, including over the counter medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820			
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other	01910			

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01910	Continued From page 47 individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed upon discharge, to document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, and names of staff and other individuals involved in the disposition for one of one discharged resident (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 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: R2 was admitted to the licensee on January 4, 2026, with diagnoses including type II diabetes, post traumatic stress disorder (PTSD), and opioid induced mood disorder. R2 discharged from the facility on June 5, 2026. R2's progress notes dated May 27, 2026, at 8:44 a.m., read: Staff came in greeted [R2's initials] she was good and wanted to go to the store then staff and them left to go and came back home then [R2's initials] got mad and wanted to leave and left to her daughter house cause she did not want to be here. Staff packed her medication and she was dropped off. R2's Discharge Summary dated June 5, 2026,	01910			

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01910	Continued From page 48 indicated: Resident (R2) out of facility at the time of discharge and refused to complete discharge assessment with RN (registered nurse). Case manager arrived to facility and obtained resident's medications and belongings. During the entrance conference on August 31, 2026, at 2:03 p.m., clinical nurse supervisor (CNS)-C stated when a resident discharges and takes their medications with them, they try to count and record each medication released. CNS-C stated R2's discharge was hurried as the resident had left the facility and didn't return. R2's case manager picked up R2's medications when CNS-C was not present in the facility. The staff working did not count or record the medications released to the case manager and should have. The licensee's Disposition and Disposal of Medications policy effective November 13, 2025, indicted: 5. Upon disposition, [Licensee name] will document the following information in the clinical record a. Name, strength and prescription number of medication, as applicable b. Quantity c. Method of disposition or to whom the medications were given d. Date of disposition e. Names(s)/signature(s) of staff or other individuals involved in disposition f. If applicable, to whom the medications were given No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910			

Minnesota Department of Health

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02320	Continued From page 49	02320			
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 one of one unlicensed personnel (ULP-E) provided services competently during 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 started receiving services on January 6, 2026, with diagnoses including paranoid schizophrenia, major depressive disorder, antisocial personality disorder, asthma, and high blood pressure. R1's Service Plan dated May 9, 2026, indicated R1 received services including assistance with medication administration.	02320			

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02320	Continued From page 50 R1's medication administration record (MAR) dated September 2026, included the following orders: - fluticasone propionate and salmeterol inhaler 500 mcg (micrograms)/50 mcg. Inhale one puff twice daily - Incruse inhaler 62.5 mcg. Inhale one puff once a day. On September 1, 2026, at 8:03 a.m., the surveyor observed unlicensed personnel (ULP)-E administering medications to R1 in the dining area. After R1 took his scheduled oral medications, ULP-E handed R1 the fluticasone propionate inhaler. R1 administered one puff independently and handed the inhaler back to ULP-E. ULP-E then immediately handed R1 his Incruse inhaler and R1 administered one puff independently. ULP-E did not instruct R1 to wait at least one minute prior to administering the second inhaler, nor did she prompt the resident to rinse his mouth afterwards. When interviewed at approximately 8:15 a.m. following the medication administration observation, ULP-E stated she always gives R1 his inhalers together and doesn't prompt the resident to wait a specified amount of time between inhalers. When asked if ULP-E ever offered/prompted the resident to rinse his mouth following administration of the fluticasone propionate and salmeterol inhaler, ULP-E stated that R1 doesn't really like to do that, so she doesn't offer. On September 1, 2026, at 11:13 a.m., clinical nurse supervisor (CNS)-C stated she trains staff to wait a couple minutes between inhaler administrations; after the fluticasone proprionate inhaler staff are to direct R1 to rinse mouth and spit after use. CNS-C stated she expected staff to do this.	02320			

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02320	Continued From page 51 The Advair Diskus (fluticasone propionate and salmeterol inhalation powder) manufacturers instructions/package insert revised December 2017, indicated: Candida albicans infection of the mouth and pharynx may occur. Monitor patients periodically. Advise the patient to rinse his/her mouth with water without swallowing after inhalation to help reduce the risk. 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

Page: 1

Establishment Info

GOLDEN HAVEN LLC
16154 Estate Lane
Lakeville, MN 55044
Dakota County
Parcel:

Phone:

License Info

License: HFID 41716

Risk:
License:
Expires on:
CFPM: Abdishakur O. Jaamar
CFPM #: 54006; Exp: 11/9/2027

Inspection Info

Report Number: F1043261257
Inspection Type: Full - Single
Date: 9/1/2026 Time: 2:36:36 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 1
Total Priority 2 Orders: 2
Total Priority 3 Orders: 4
Delivery:

New Order: 3-300C Protection from Contamination: equipment/utensils, consumers

3-304.14B *Priority Level: Priority 3 CFP#: 41*

MN Rule 4626.0285B Wiping cloths used for wiping counters and other equipment surfaces must be held in an approved sanitizing solution and laundered daily.

COMMENT: WET CLOTH STORED BESIDE KITCHEN SINK. ADVISED STAFF TO STORE WET CLOTHS IN A SANITIZER SOLUTION (PROVIDE CORRESPONDING TEST KIT TO MEASURE CONCENTRATION) IN BETWEEN USES OR TO USE A DRY, CLEAN CLOTH EACH TIME. COMPLY WITH ABOVE RULE.

Comply By: 9/1/2026 Originally Issued On: 9/1/2026

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: SLICED TOMATO IN FRIDGE OBSERVED WITH NO DATE MARK. STAFF CONFIRMED TOMATO WAS SLICED THE PREVIOUS DAY. ADVISED STAFF TO DATE MARK AND DISCARD LEFTOVERS AFTER 7 DAYS. FACT SHEET PROVIDED WITH REPORT.

Comply By: 9/1/2026 Originally Issued On: 9/1/2026

! New Order: 3-500D Microbial Control: disposition of food

3-501.18A *Priority Level: Priority 1 CFP#: 23*

MN Rule 4626.0405A Discard all TCS food prepared in the establishment or opened commercially packaged food when the time exceeds 7 days from the preparation or opening date or if the container or package is not marked.

COMMENT: OBSERVED MULTIPLE TCS CONTAINERS OF HEAVY CREAM AND BAGS OF LETTUCE IN FRIDGE WITH A DATE MARK OF 8/20/26. ADVISED STAFF TO DISCARD. COMPLY WITH ABOVE RULE.

Comply By: 9/1/2026 Originally Issued On: 9/1/2026

New Order: 4-300 Equipment Numbers and Capacities

4-302.12B *Priority Level: Priority 2 CFP#: 36*

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

COMMENT: NO THERMOMETER AVAILABLE ON SITE. ADVISED STAFF TO PROVIDE, MAINTAIN, AND REGULARLY CALIBRATE. COMPLY WITH ABOVE RULE.

Comply By: 9/1/2026 Originally Issued On: 9/1/2026

New Order: 4-600 Cleaning Equipment and Utensils4-601.11C *Priority Level: Priority 3 CFP#: 49*

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

COMMENT: FOOD STAINS OBSERVED IN INTERIOR OF KITCHEN FREEZER. ADVISED STAFF TO CLEAN AND MAINTAIN CLEAN. COMPLY WITH ABOVE RULE.

Comply By: 9/1/2026 Originally Issued On: 9/1/2026

New Order: 4-900 Protecting Clean Items4-903.11A *Priority Level: Priority 3 CFP#: 44*

MN Rule 4626.0955A Store all clean equipment, utensils, linens, single-service and single-use articles in a clean dry location where not exposed to splash, dust, or other contamination and at least six inches above the floor.

COMMENT: DRY STORAGE ROOM LOCATED BESIDE KITCHEN. PACK OF TOILET PAPER STORED ON THE FLOOR. ADVISED STAFF TO RELOCATE ITEMS TO AN APPROVED HEIGHT. STAFF CORRECTED ON SITE. COMPLY WITH ABOVE RULE.

Comply By: 9/1/2026 Originally Issued On: 9/1/2026

New Order: 6-200 Physical Facility Design and Construction6-202.15D *Priority Level: Priority 3 CFP#: 38*

MN Rule 4626.1395D Protect the outside openings of the food establishment if the doors and windows are kept open for ventilation or other purposes by providing and maintaining tightly fitting screens (not less than 16 mesh to 1 inch), air curtains, or using other effective means.

COMMENT: SLIDING DOOR BY KITCHEN OBSERVED CRACKED OPEN WITH DOOR SCREEN WIDE OPEN. ADVISED STAFF TO CLOSE DOOR SCREEN WHEN SLIDING DOOR IS OPENED TO PREVENT PEST ENTRANCE/CONTAMINATION. COMPLY WITH ABOVE RULE.

Comply By: 9/1/2026 Originally Issued On: 9/1/2026

Food & Beverage General Comment

Inspection was completed with Wendy Buckholz as the lead Health Regulation Division Nurse Evaluator completing the site survey.

TEMPERATURE (F)

KITCHEN FRIDGE: HEAVY CREAM 40, LETTUCE 41, CHEESE 39

UTENSIL SURFACE TEMPERATURE (F)

DISH MACHINE: LAST TEST RUN BY FACILITY WAS ON 8/27/26 AND MEASURED AT LEAST 160F. TEST IS TYPICALLY RUN ON A MONTHLY BASIS.

Discussed highly susceptible populations, date marking, illness policy, sanitizer use, ware washing, temperature control, same day food service, cleaning, pest control, vomit/fecal procedures, test kits, food storage, and food handling procedures.

This facility has a residential kitchen with residential equipment: wooden cabinetry, hardwood flooring, smooth walls, and textured ceilings, dish machine with sani rinse option. Conditions of equipment and physical facility will be monitored during future inspections – must be brought up to code if at such time they are found to be a concern or risk of contamination.

Contact Health Regulation Division for plan review approval when facility/kitchen undergoes remodeling, major equipment additions, or changes of equipment due to a menu change.

***Notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation.

If any customer complains of illness, establishment is required to notify the Minnesota Department of Health and provide the foodborne illness hotline phone number to the customer: 1-877-366-3455

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 F1043261257 from 9/1/2026

Abdishakur O. Jaamar
CFPM



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Public Health Sanitarian 1
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Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL41716015-0	Date: 9/1/2026
Facility Name: Golden Haven LLC	
Facility Address: 16154 Estate Lane, Lakeville, MN 55044	

☒ TAG IDENTIFICATION: 0775

SCOPE/ SEVERITY: Level 2; Pattern

TIME PERIOD OF CORRECTION: Seven (7) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]
2. Egress doors shall be readily operable from the egress side without the use of a key or special knowledge. [Minn. Stat. 144G.45 subd. 2; MSFC 1010.1.9]

Comments: The west marked exit door had a hotel door latch installed.

The staff office had a cable-style lock on the non-egress side. With this lock installed and locked, egressing from this room is not possible.

☒ TAG IDENTIFICATION: 0800

SCOPE/ SEVERITY: Level 1; Widespread

TIME PERIOD OF CORRECTION: Twenty One (21) 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 lower-level common room window screen was damaged.

Resident rooms 1 and 5 both had missing window screens.

Resident room 1 did not have the entrance door installed.

The clothes dryer venting was disconnected allowing the dryer to vent into the facility.

The main level patio door screen door had multiple holes.