Electronically Delivered

March 31, 2025

Licensee
Solace Healing, LLC
5909 Quail Avenue North
Crystal, MN 55429

RE: Project Number(s) SL40733015

Dear Licensee:

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

The Minnesota Department of Health completed an initial survey on February 27, 2025, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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

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

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.

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

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

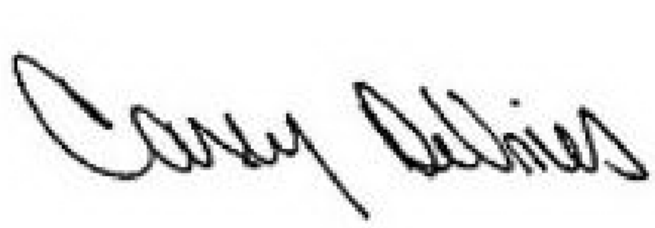
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,



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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40733	A. BUILDING: _____ B. WING _____	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLACE HEALING, LLC	5909 QUAIL AVE N CRYSTAL, MN 55429

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0 000	Initial Comments 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: SL40733016-0 On February 24, 2025, through February 27, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were two resident(s); two receiving services under the Provisional Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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, Food and Beverage Establishment Inspection Report (FBEIR) dated February 26, 2025, 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		

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0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that functioned and were interconnected so that the actuation of one alarm caused all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 780		

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0 780	Continued From page 4 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: On February 25, 2025, from 10:00 a.m. to 11:30 a.m., the surveyor toured the facility with house manager (HM)-B. The surveyor asked HM-B to initiate a test of the smoke alarms throughout the home. Upon testing, the smoke alarms in the following locations did not sound when the test button was pressed: The smoke alarm battery in bedroom 5 was not installed correctly, HM-B put the battery back into the smoke alarm and it sounded but continued to beep indicating the battery needed replacement. The smoke alarm in the upstairs hallway was not interconnected with the rest of the smoke alarms in the facility. HM-B visually verified these deficient findings at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping	0 810		

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0 810	Continued From page 5 rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and to provide the required training. This had the potential to directly 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	0 810		

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0 810	Continued From page 6 safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On February 25, 2025, house manager (HM)-B provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "Fire Safety", dated February 7, 2024, failed to include the following: The FSEP failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The provided FSEP was from a third-party provider and had not been updated to the specific facility. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. On February 25, 2025, at 12:00 p.m., HM-B stated they didn't understand that the third-party policy they were using was not correct. HM-B stated they would work on developing their FSEP. The policy reviewed was an unedited policy from a third-party provider that was not specific to the facility.	0 810		

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0 810	Continued From page 7 TRAINING: The licensee failed to provide evacuation training to residents at least once per year. HM-B lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. HM-B lacked documentation showing any training was offered or training was scheduled for a future date for employees on the fire safety and evacuation plan. On February 25, 2025, at 12:00 p.m., HM-B stated they did not currently have a training specific to the fire safety and evacuation plan for their facility. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01750 SS=F	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced	01750		

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01750	Continued From page 8 by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) specified in writing, specific instructions for medication administration for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted to the assisted living facility on August 12, 2024, and began receiving assisted living services. R1's Service Plan dated August 12, 2024, indicated R1 received assistance with medication administration. R1's signed After Visit Summary (AVS) dated February 13, 2025, indicated R1 was prescribed topiramate 25 milligram (mg) 1 to 2 tabtles at bedtime. R1's Medication Administration Record (MAR) dated February 1, 2025, through February 24, 2025, indicated topiramate 25-50 mg 1 to 2 tablets at bedtime. R1's record lacked parameter instruction for unlicensed personnel (ULP) to be able to	01750		

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01750	Continued From page 9 determine how topiramate should be administered and when to administer one or two tablets. R2 R2 was admitted to the assisted living facility on November 18, 2024, and began receiving assisted living services. R2's Service Plan dated November 18, 2024, indicated R2 received assistance with medication administration. R2's record contained an electronically signed order for hydroxyzine 25 mg. The directions for the medication were take 1 to 2 tablets 3 times daily as needed. R2's MAR dated February 1, 2025, through February 24, 2025, indicated hydroxyzine hydrochloride 25-50 mg 1-2 tablets three times daily as needed. R2's record lacked parameter instruction for ULP to be able to determine how hydroxyzine hydrochloride should be administered and when two administer one or two tablets. On February 25, 2025, at 9:46 a.m., the surveyor inquired if there were parameters for the topiramate 25-50 mg for R1 and the hydroxyzine 25-20 mg for R2. The surveyor observed HM-B look through RTasks (web-based electronic health record (EHR) platform). HM-B stated there were no parameters. On February 25, 2025, at 9:52 a.m., clinical nurse supervisor (CNS)-C stated they trained staff to ask residents how they were feeling to determine how many medications should be administered.	01750		

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01750	Continued From page 10 CNS-C stated they were unaware parameter instructions should be available for ULP. The licensee's Medication Administration Policy dated February 7, 2025, indicated the RN would prepare written instructions for staff to administer medications properly. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review licensee failed to ensure prescriber orders were transcribed as ordered for one of two residents (R2). This practice resulted in a level two violation (a	01760		

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01760	Continued From page 11 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: R2 was admitted to the assisted living facility on November 18, 2024, and began receiving assisted living services. R2's Service Plan dated November 18, 2024, indicated R2 received assistance with medication administration. R2's record contained a document titled New Prescription Summary dated February 18, 2025, electronically signed by the medical provider. The document indicated R2 was prescribed disulfiram 250 mg 1 tablet at bedtime. R2's Medication Administration Record (MAR) dated February 1, 2025, through February 25, 2025, indicated the licensee's staff had administered disulfiram 250 mg 2 tablets (500mg) at 8:00 a.m., daily. On February 25, 2025, at 7:55 a.m., the surveyor observed house manager (HM)-B administer medications to R2. The surveyor observed on the electronic medical record (EMAR) for 8:00 a.m., that R2 was to be administered disulfiram 250 mg 2 tablets (500 mg). The surveyor observed HM-B place the following medication into the medication cup for R2: amlodipine 5 mg, atorvastatin 5 mg, bupropion 150 mg, and escitalopram 5 mg. The	01760		

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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
01760	Continued From page 12 disulfiram 250 mg tablets were not in the pre-set-up medication container. On February 25, 2025, at 8:13 a.m., CNS-C stated staff were trained to verify the medications by performing a count and were supposed to contact them if there was a discrepancy between the number of medication pills available and the number of medication pills listed on the MAR. CNS-C stated at a recent doctor's appointment, R1's dose of disulfiram medication dose was changed from 500 mg to 250 mg, and the time of administration was changed from morning time to bedtime. CNS-C stated they were unsure why the EMAR was still displaying disulfiram 500 mg to be administered at 8:00 a.m. On February 25, 2025, at 8:23 a.m., HM-B stated they were trained by the CNS to verify medications prior to administering medications. HM-B they forgot to verify the medications before administering them to R2. On February 25, 2025, at 8:30 a.m., the surveyor observed a pill bottle with R2's identifier with a dispense date of February 12, 2025, in the facility's medication cabinet along with R2's other medications. The pharmacy label indicated R2 was prescribed disulfiram 250 mg 1 tablet once daily. The surveyor observed there were tablets in the prescription bottle. Although the medication was present and available to staff for administration, HM-B did not administer the medication. On February 25, 2025, at 1:41 p.m., and 2:11 p.m., LALD-D stated the CNS was responsible for ensuring prescriber orders matched the MAR. The licensee's Medication Administration policy	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40733	A. BUILDING: _____ B. WING _____	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLACE HEALING, LLC	5909 QUAIL AVE N CRYSTAL, MN 55429

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01760	Continued From page 13 dated February 7, 2024, indicated residents were entitled to safe administration of medications by qualified personnel according to a written Medication Management Plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
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 maintain current medication orders for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted to the assisted living facility on November 18, 2024, and began receiving assisted living services.	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40733	A. BUILDING: _____ B. WING _____	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01820	Continued From page 14 R2's Service Plan dated November 18, 2024, indicated R2 received assistance with medication administration. R2's medication administration record dated February 1, 2025, through February 24, 2025, indicated R2 received the following medications: Advair Diskus 0.50 micrograms (mcg) inhale 1 puff twice daily, amlodipine 5 milligram (gm) 1 tablet once daily, atorvastatin 20 mg 1 tablet once daily, bupropion 150 mg 1 tablet once daily, disulfiram 250 mg 2 tablets once daily, escitalopram 20 mg 1 tablet once daily, nicotine transdermal (through the skin) apply 1 patch topically (place on skin) once daily, melatonin 10 mg 2 tablets once daily at bedtime, acetaminophen 650 mg every 4 hours as needed, albuterol sulfate inhale 2 puffs every 4 hours as needed, hydroxyzine hydrochloride 1-2 tablets three times daily as needed and, Robitussin 5 milliliter (ml) every 4 hours as needed. R2's record contained a document titled CVS/Pharmacy Prescription Transfer dated December 12, 2024. The document indicated R2 was dispensed nicotine 7 mg/24-hour patch. The document lacked an electronic or manual signature from a medical prescriber. On February 25, 2025, at 7:55 a.m., the surveyor observed house manager (HM)-B offer the nicotine patch to R2. R2 declined the nicotine patch. On February 25, 2025, at 9:46 a.m., clinical nurse supervisor (CNS)-C stated they were informed by the pharmacy the document was considered a legal document and was a valid prescription order.	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40733	A. BUILDING: _____ B. WING _____	02/27/2025

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01820	Continued From page 15 On February 25, 2025, at 1:38 p.m., licensed assisted living director (LALD)-D stated the clinical nurse supervisor was responsible for ensuring there were signed orders for medications. LALD-D stated they were aware the order should be signed by the medical prescriber. The licensee's Prescriber Orders dated February 7, 2024, indicated all orders must be signed and dated by the prescriber. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure time sensitive medications were labeled with the date opened and name of the resident and failed to discard expired medication for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40733	A. BUILDING: _____ B. WING _____	02/27/2025

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01890	Continued From page 16 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 to the assisted living facility on August 12, 2024, and began receiving assisted living services. R1's Service Plan dated August 12, 2024, indicated R1 received assistance with medication administration. R1's Medication Administration Record (MAR) dated February 1, 2025, through February 24, 2025, indicated R1 received the following medications: insulin aspart inject 70/25 twice daily inject 70 units (u) twice daily inject subcutaneously for blood sugars under 300, and inject 80 units daily for blood glucose 300 and higher, gabapentin 900 milligrams (gm) three times daily, lisinopril hydrochlorothiazide 20-12.5 mg one-half tablet once daily, pantoprazole 40 once daily, ropinirole 1 mg once daily, amlodipine 5 mg once daily, aspirin 81 mg once daily, atenolol 50 mg once daily, atorvastatin 40 mg once daily, acetaminophen 650 mg every 4 hours as needed, gabapentin 600 1 tablet at bedtime, polyethylene glycol 3350 17 grams (g) once daily as needed, Robitussin 5 milliliters every 4 hours as needed, tizanidine 4 mg 1 tablet at bedtime, and topiramate 25-50 1 to 2 tablets at bedtime. The MAR lacked parameters when to hold the administration of insulin. On February 24, 2025, at 10:45 a.m., the	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01890	Continued From page 17 surveyor observed the licensee's medication cabinet which contained an insulin aspart injection pen (a device used to inject medications) that contained no resident name with R1's other medications. There was no opened on dated noted on the insulin injection pen. On February 24, 2025, at 10:54 a.m., and February 25, 2025, at 2:24 p.m., clinical nurse supervisor (CNS)-C stated staff were trained to label the medication with an opened-on date. CNS-C stated the insulin pen could be used up to seven days after being removed from the refrigerator. CNS-C stated the insulin pen was opened February 22, 2025, but was unable to provide documentation to corroborate the statement. CNS-C stated staff should have labeled the insulin pen with an opened date, and it was an oversight for not labeling the insulin pen. The manufacturer's storage guidelines for insulin aspart injection pen dated 2007 recommended unrefrigerated insulin pens must be discarded 10 days after being removed from the refrigerator. The licensee's Storage/Control of Medications policy dated February 7, 2024, indicated the licensee would store medications according to the manufacturer's directions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

Minnesota Department of Health

625 Robert Street North
St Paul
651-201-4500

Type: Full
Date: *02/26/25*
Time: 12:56:16
Report: 7994251051

Food and Beverage Establishment Inspection Report

Location:
Solace Healing, LLC
5909 Quail Avenue North
Crystal, MN55429
Hennepin County, 27

Establishment Info:
ID #: 0038954
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6122728118
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

6-300 Physical Facility Numbers and Capacities

6-301.12 ***** Priority 2 *****

MN Rule 4626.1445 Provide and maintain a supply of individual disposable towels, a continuous towel system, a heated-air hand drying device, or an approved ambient air temperature hand drying device at each handwashing sink or group of adjacent handwashing sinks.

PAPER TOWELS FOUND JUST SITTING ON COUNTER TOP. PROVIDE A PAPER TOWEL DISPENSER FOR PAPER TOWELS.

Comply By: 02/26/25

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

THERE IS A CURRENT FOOD SAFETY CERTIFICATE BUT NO CURRENT MINNESOTA CFPM. INCLUDED INFO IN EMAIL.

Comply By: 02/26/25

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	1	1

INSPECTION CONDUCTED AT THE PRESENCE OF HRD STAFF AND FINDINGS SHARED AT THE END OF INSPECTION.

WILL EMAIL SUPPORTING DOCUMENTS AND LINKS TO HRD STAFF AT THE END OF THE DAY.

KITCHEN IS RESIDENTIAL AND FOOD IS PREPARED FOR SAME DAY SERVICE.

Food and Beverage Establishment Inspection Report

FLOOR IS VINYL, CABINETS ARE WOOD WITH HALLOWED ENCLOSED BASES, LAMINATE COUNTER TOPS AND SMOOTH CEILING. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT ANY TIME THERE IS FOUND TO BE A RISK OF CONTAMINATION OR CONCERN THE PHYSICAL FACILITIES WILL BE REQUIRED TO BE BROUGHT UP TO CODE.

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 7994251051 of 02/26/25.

Certification Number: _____ Expires: __/__/_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Establishment Representative

Signed: Crystal Elva

Crystal Elva
Public Health Sanitarian 3
St Paul
651-201-3981
Crystal.Elva@state.mn.us

Report #: 7994251051

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health

625 Robert Street North
St Paul

No. of RF/PHI Categories Out	2	**Date**	02/26/25
No. of Repeat RF/PHI Categories Out	0	**Time In**	12:56:16
Legal Authority MN Rules Chapter 4626		**Time Out**	

Solace Healing, LLC	**Address** 5909 Quail Avenue North	**City/State** Crystal, MN	**Zip Code** 55429	**Telephone** 6122728118
License/Permit # 0038954	**Permit Holder**	**Purpose of Inspection** Full	**Est Type**	**Risk Category**

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

	Compliance Status					COS	R
Supervision							
1	(IN)	OUT			PIC knowledgeable; duties & oversight		
2	IN	(OUT)	N/A		Certified food protection manager, duties		
Employee Health							
3	(IN)	OUT			Mgmt/Staff;knowledge,responsibilities&reporting		
4	(IN)	OUT			Proper use of reporting, restriction & exclusion		
5	(IN)	OUT			Procedures for responding to vomiting & diarrheal events		
Good Hygenic Practices							
6	(IN)	OUT		N/O	Proper eating, tasting, drinking, or tobacco use		
7	(IN)	OUT		N/O	No discharge from eyes, nose, & mouth		
Preventing Contamination by Hands							
8	(IN)	OUT		N/O	Hands clean & properly washed		
9	(IN)	OUT	N/A	N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	IN	(OUT)			Adequate handwashing sinks supplied/accessible		
Approved Source							
11	(IN)	OUT			Food obtained from approved source		
12	IN	OUT	N/A	(N/O)	Food received at proper temperature		
13	(IN)	OUT			Food in good condition, safe, & unadulterated		
14	IN	OUT	(N/A)	N/O	Required records available; shellstock tags, parasite destruction		
Protection from Contamination							
15	(IN)	OUT	N/A	N/O	Food separated and protected		
16	(IN)	OUT	N/A		Food contact surfaces: cleaned & sanitized		
17	(IN)	OUT			Proper disposition of returned, previously served, reconditioned, & unsafe food		

	Compliance Status					COS	R
Time/Temperature Control for Safety							
18	IN	OUT	N/A	(N/O)	Proper cooking time & temperature		
19	IN	OUT	(N/A)	N/O	Proper reheating procedures for hot holding		
20	IN	OUT	(N/A)	N/O	Proper cooling time & temperature		
21	IN	OUT	(N/A)	N/O	Proper hot holding temperatures		
22	(IN)	OUT	N/A		Proper cold holding temperatures		
23	(IN)	OUT	N/A	N/O	Proper date marking & disposition		
24	IN	OUT	(N/A)	N/O	Time as a public health control: procedures & records		
Consumer Advisory							
25	IN	OUT	(N/A)		Consumer advisory provided for raw/undercooked food		
Highly Susceptible Populations							
26	IN	OUT	(N/A)		Pasteurized foods used; prohibited foods not offered		
Food and Color Additives and Toxic Substances							
27	IN	OUT	(N/A)		Food additives: approved & properly used		
28	(IN)	OUT			Toxic substances properly identified, stored, & used		
Conformance with Approved Procedures							
29	IN	OUT	(N/A)		Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
Safe Food and Water				
30	IN OUT (N/A)	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT (N/A)	Variance obtained for specialized processing methods		
Food Temperature Control				
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT (N/A) N/O	Plant food properly cooked for hot holding		
35	(IN) OUT N/A N/O	Approved thawing methods used		
36		Thermometers provided & accurate		
Food Identification				
37		Food properly labled; original container		
Prevention of Food Contamination				
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
Proper Use of Utensils				
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
Utensil Equipment and Vending				
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 02/26/25

Inspector (Signature) Crystal Elva