Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

September 17, 2025

Licensee
Cultivate Care LLC
4333 Medary Avenue
Eagan, MN 55122

RE: Project Number(s) SL40415015

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 July 8, 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

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

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

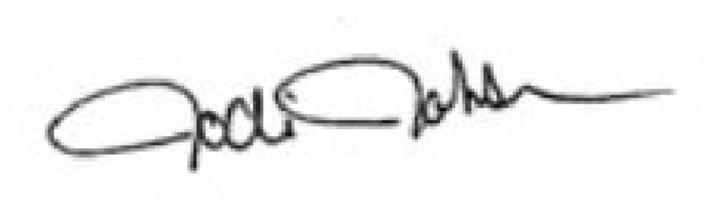
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration or a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms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

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



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

KKM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40415	A. BUILDING: _____ B. WING _____	07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CULTIVATE CARE LLC	4333 MEDARY AVENUE EAGAN, MN 55122

(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: SL40415015-0 On July 7, 2025, through July 8, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were two residents; two receiving services under the Provisional Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a staffing plan to determine staffing levels to meet the needs of all residents; and failed to ensure the staffing schedule was posted as required. 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	0 470		

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0 470	Continued From page 2 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held a Provisional Assisted Living Facility license. The facility was licensed for a capacity of five and had a current census of two residents. On July 7, 2025, at 10:32 a.m. during the facility tour with clinical nurse supervisor (CNS)-B, the surveyor did not observe the daily staffing schedule. On July 8, 2025, at 8:35 a.m., CNS-B stated the staffing schedule was maintained electronically and did not post a daily schedule. On July 8, 2025, at 1:28 p.m., operations officer (OO)-A stated the licensee had not developed a staffing plan. No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter	0 480		

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0 480	Continued From page 3 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 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part	0 480		

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0 480	Continued From page 4 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, 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, July 8, 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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0 550	Continued From page 5	0 550		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post in a conspicuous place, information about the licensee's grievance procedure with the required content. This had the potential to affect the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 550		

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0 550	Continued From page 6 The findings include: On July 7, 2025, at 10:32 a.m. during the facility tour with clinical nurse supervisor (CNS)-B, the surveyor observed the licensee's grievance procedure posted by the front door of the facility. Although the posted grievance procedure included the contact information for the Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, and the person responsible for handling resident grievances, the posting lacked information regarding the Minnesota Adult Abuse Reporting Center (MAARC). On July 7, 2025, at 1:25 p.m., CNS-B reviewed the posted grievance procedure and stated it did not include information regarding MAARC. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 630 SS=F	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	0 630		

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0 630	Continued From page 7 abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for the licensee's two residents (R1 and R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted on April 15, 2025, with diagnoses that included osteoporosis (a condition in which bones become weak and brittle). R1's service plan dated April 14, 2025, indicated R1 received services to include activity assistance, ambulation, bathing, behavior management, medication reminder, medication administration and medication setup. R1's IAPP dated May 14, 2025, identified the following areas of vulnerability: -hoarding -anxiety -depression	0 630		

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0 630	Continued From page 8 R1's IAPP did not include specific interventions for the identified vulnerabilities listed above as required. R2 R2 was admitted on June 27, 2025, with diagnoses that included Lewy body dementia (progressive form of dementia that affects thinking, reasoning, and information processing). R2's service plan dated June 27, 2025, indicated R2 received services to include activity assistance, ambulation, bathing, bedmaking, dressing, grooming, incontinence care, behavior management, safety checks and medication administration. R2's IAPP dated July 7, 2025, did not include the following required items: -the resident's susceptibility to abuse by another individual, including other vulnerable adults -statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults R1's IAPP identified the following areas of vulnerability: -agitation -hoarding -verbal aggression -disoriented R2's IAPP did not include specific interventions for the identified vulnerabilities listed above as required. On July 8, 2025, at 8:16 a.m., clinical nurse supervisor (CNS)-B reviewed R1 and R2's IAPP and stated the IAPPs did not include interventions	0 630		

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0 630	Continued From page 9 for the identified vulnerabilities as noted above. CNS-B stated R2's IAPP did not include R2's susceptibility to abuse by other individuals. The licensee's Individual Abuse Prevention Plan policy dated May 2024, indicated the IAPP would include: -individualized review or assessment of the resident's susceptibility to be abused by another individual, including other vulnerable adults; -the resident's risk of abusing other vulnerable adults; -specific measures to minimize the risk of abuse to that person and other vulnerable adults; and -measures to minimize the risk of self-abuse, if applicable. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language.	0 640		

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0 640	Continued From page 10 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to support protection and safety by not posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) as required. The licensee also failed to post the 911 emergency number in common areas and near telephones provided by the assisted living facility. 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: On July 7, 2025, at 10:32 a.m. during the facility tour with clinical nurse supervisor (CNS)-B, the surveyor did not observe any signage or information posted regarding the 911 emergency number or post information and the reporting number for MAARC to report suspected maltreatment of a vulnerable adult under section 626.557. On July 7, 2025, at 10:39 a.m., CNS-B stated the 911 emergency number was not posted. In addition, CNS-B stated the MAARC information was not posted either. No further information was provided.	0 640		

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0 640	Continued From page 11 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all residents, staff, and visitors of the facility.	0 680		

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CULTIVATE CARE LLC	4333 MEDARY AVENUE EAGAN, MN 55122

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0 680	Continued From page 12 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's undated, Emergency Preparedness plan was reviewed and lacked the following: - policy and procedure for a system to track the location of on duty staff and sheltered residents and if on duty staff and sheltered residents are relocated, the facility must document the specific name/location of the receiving facility or other location; - policy and procedure addressing use of volunteers, including the process/role for integration; - policy and procedure addressing the role of facility under waiver declared by the Secretary in accordance with section 1135 of the ACT; - communication plan which includes names/contact information: staff, entities providing services under agreement, residents' physicians, other facilities, volunteers; - communication plan must include contact information for the following: MN Office of Ombudsman for LTC -arrangements with other faculties. - conduct exercises to test EP at least twice per year, including unannounced staff drills using EP, including participating in an annual full-scale exercise community based or annual individual	0 680		

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0 680	Continued From page 13 facility based functional exercise or if facility experiences an actual emergency requiring evacuation of plan, facility is exempt from engaging in its next required full scale exercise; conduct an additional annual exercise that may include a second full scale exercise community based or an individual; facility based functional exercise or mock disaster drill or table top exercise. On July 8, 2025, at 1:47 p.m., operations officer (OO)-A stated the licensee's current EP plan did not include the above content. OO-A stated the EP plan was a work in progress with their consultant. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 790 SS=F	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by:	0 790		

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0 790	Continued From page 14 Based on observation and interview, the licensee failed to provide or maintain fire extinguishers as required throughout the facility. This deficient condition had the ability to affect all staff, visitors, 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 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 July 8, 2025, from 10:30 a.m. to 1:00 p.m., the surveyor toured the facility with operations officer (OO)-A. During the tour, the surveyor observed: FIRE EXTINGUISHER: Both portable fire extinguishers in the facility showed the required annual service was not completed in 2024 with extinguisher showing a 2023 manufacturing date. All fire extinguishers are overdue for annual service. On July 8, at 12:30 p.m., OO-A, verified this deficient finding. TIME PERIOD FOR CORRECTION: Two (2) days.	0 790		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The	0 810		

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0 810	Continued From page 15 plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors.	0 810		

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0 810	Continued From page 16 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 potential to affect a large portion or all of the residents). The findings include: July 8, 2025, from 10:30 a.m. to 1:00 p.m., with operations officer (OO)-A provided documents on the FSEP, fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "Fire Safety and Evacuation", dates 5/2024, failed to include the following: STAFF ACTIONS: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate). The provided FSEP was from a third-party provider and had not been updated to the specific facility. RESIDENT ACTIONS: 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. UNIQUE AND UNUSUAL RESIDENT NEEDS:	0 810		

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0 810	Continued From page 17 The facility uses an electronic care plan website for standard resident evacuation procedures. The FSEP does not include instructions on how to use or what do in the loss of power/internet event for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. On July 8, 2025, at 12:30 p.m., OO-A stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. TRAINING: The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. OO-A misunderstood the statute requirements, not recognizing themselves and nurse as staff. No other staff was hired until 2025, new staff does web-based training and verbal training. Facility didn't have a resident until April 2025, allowing time to complete resident training. No other training documentation was provided. On July 8, 2025, at 12:30 p.m., OO-A stated they now understand the requirements for training staff and would implement a training program that was compliant with statute requirements. DRILLS The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. OO-A stated that the facility has only had a resident as of April 2025 despite having a license since 2024. OO-A provided documentation of evacuation drills being conducted in April and June of 2025. OO-A was under the impression that drills weren't required until residents moved	0 810		

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0 810	Continued From page 18 into the facility. On July 8, 2025, at 12:30 p.m., OO-A stated there were no additional documented drills for the facility, and they understand the statute requirements for drills. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 900 SS=F	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to	0 900		

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0 900	Continued From page 19 any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to have a signed assisted living contract for the licensee's two residents (R1 and R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted on April 15, 2025, with diagnoses that included osteoporosis (a condition in which bones become weak and brittle). R1's service plan dated April 14, 2025, indicated R1 received services to include activity assistance, ambulation, bathing, behavior management, medication reminder, medication administration and medication setup. R1's record included a Resident contract dated April 14, 2025. The document was signed by R1 but lacked a signature from the licensee. R2 R2 was admitted on June 27, 2025, with	0 900		

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0 900	Continued From page 20 diagnoses that included Lewy body dementia (progressive form of dementia that affects thinking, reasoning, and information processing). R2's service plan dated June 27, 2025, indicated R2 received services to include activity assistance, ambulation, bathing, bedmaking, dressing, grooming, incontinence care, behavior management, safety checks and medication administration. R2's record included a Resident contract dated June 27, 2025. The document was signed by R2 but lacked a signature from licensee. On July 8, 2025, at 12:59 p.m., operations officer (OO)-A reviewed R1 and R2's resident contracts and stated the licensee had not signed either of the contracts. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 900		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal	01370		

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01370	Continued From page 21 hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency was completed for two of two employees (unlicensed personnel (ULP)-E and ULP-G) to include all required content. 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	01370		

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01370	Continued From page 22 cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-E ULP-E was hired on June 7, 2025, to provide direct care and services to the facility's residents. ULP-E's employee record lacked evidence of training for the following topics: -basic infection control, including blood-borne pathogens; -maintenance of a clean and safe environment; -training on the prevention of falls; -communication skills that include preserving the dignity of the resident and showing resident for the resident and the resident's preferences, cultural background, and family. ULP-E's employee record lacked evidence of competency evaluation for the following topics: -appropriate and safe techniques in personal hygiene and grooming including: -hair care and bathing -care of teeth, gums, and oral prosthetic devices -care and use of hearing aids -dressing and assistance with toileting -standby assistance techniques and how to perform them ULP-G ULP-G was hired on April 9, 2025, to provide direct care and services to the facility's residents. ULP-G's employee record lacked evidence of	01370		

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01370	Continued From page 23 training for the following topics: -documentation requirements for all services provided; -reports of changes in resident's condition to the supervisor designated by the facility: ULP-G's employee record lacked evidence of competency evaluation for the following topics: -appropriate and safe techniques in personal hygiene and grooming including: -hair care and bathing -care of teeth, gums, and oral prosthetic devices -care and use of hearing aids -dressing and assistance with toileting -standby assistance techniques and how to perform them On July 8, 2025, at 10:46 a.m., clinical nurse supervisor (CNS)-B stated ULP-E and ULP-G's records lacked the required training and competencies as listed above. CNS-B stated the licensee is in the process of updating their training program to ensure all required training and competencies are completed by all staff. The licensee's Required Training and Education, Orientation, Annual, Dementia Care policy, undated indicated training would consist of the following topics: -documentation requirements for all services provided -reports of changes in the resident's condition to the supervisor designated by the facility -basic infection control, including blood-borne pathogens -maintenance of a clean and safe environment -appropriate and safe techniques in personal hygiene and grooming, including: hair care and bathing, care of teeth, gums and oral prosthetic	01370		

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01370	Continued From page 24 devices, care and use of hearing aids, dressing ad assistance with toileting -prevention of falls -standby assistance techniques and how to perform them -medication, exercise, and treatment reminders -basic nutrition, meal preparation, food safety, and assistance with eating -preparation of modified diets as ordered by a licensed health professional -communications kills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family respect for the resident and the resident's preferences, cultural background, and family -awareness of confidentiality and privacy -understanding appropriate boundaries between staff and residents and the resident's family -procedures to use in handling various emergency situations -awareness of commonly used health technology equipment and assistive devices No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other	01380		

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01380	Continued From page 25 observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency was completed for two of two employees (unlicensed personnel (ULP)-E and ULP-G) to include all required content. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-E ULP-E was hired on June 7, 2025, to provide direct care and services to the facility's residents. ULP-E's employee record lacked evidence of training for the following topics: -safe transfer techniques and ambulation; ULP-E's employee record lacked evidence of	01380		

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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
01380	Continued From page 26 competency evaluation for the following topics: -reading and recording temperature, pulse, and respirations of the resident; -safe transfer techniques and ambulation; -range of motion and positioning; -administering treatments ULP-G ULP-G was hired on April 9, 2025, to provide direct care and services to the facility's residents. ULP-G's employee record lacked evidence of training for the following topics: -observing, reporting, and documenting of resident status; ULP-G's employee record lacked evidence of competency evaluation for the following topics: -reading and recording temperature, pulse, and respirations of the resident; -safe transfer techniques and ambulation; -range of motion and positioning; -administering treatments On July 8, 2025, at 10:46 a.m., clinical nurse supervisor (CNS)-B stated ULP-E and ULP-G's records lacked the required training and competencies as listed above. CNS-B stated the licensee is in the process of updating their training program to ensure all required training and competencies are completed by all staff. The licensee's Required Training and Education, Orientation, Annual, Dementia Care policy, undated indicated training would consist of the following topics: -observing, reporting, and documenting resident status -basic knowledge of body functioning and changes in body functioning, injuries, or other	01380		

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	40415	A. BUILDING: _____ B. WING _____	07/08/2025

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01380	Continued From page 27 observed changes that must be reported to appropriate personnel -reading ad recording temperature, pulse, and respirations of the resident -recognizing physical, emotional, cognitive, and developmental needs of the resident -safe transfer techniques and ambulation -range of motioning and positioning -administering medications or treatments as required No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01530 SS=D	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under	01530		

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01530	Continued From page 28 paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of two employees (unlicensed personnel (ULP)-G) received the required amount of dementia care training in the required time frame. 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:	01530		

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01530	Continued From page 29 ULP-G was hired on April 9, 2025, to provide direct care and services to the facility's residents. ULP-G's employee record contained evidence the employee received seven hours of dementia care training, not the required eight hours of training within 160 working hours of the employment start date. On July 8, 2025, at 9:57 a.m., Operations officer (OO)-A stated ULP-G's record lacked the required eight hours of dementia care training. Clinical nurse supervisor (CNS)-B reviewed ULP-G hours worked and stated he had worked more than 160 hours. The licensee's Required Training and Education, Orientation, Annual, Dementia Care policy, undated indicated staff would complete 8 hours of dementia care training within first 160 hours of employment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530		
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	01610		

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01610	Continued From page 30 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 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 the licensee's two residents (R1 and R2) prior to the 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 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's diagnoses included osteoporosis (a condition in which bones become weak and brittle). R1's Resident Contract was signed on April 14, 2025. R1 started receiving assisted living services on	01610		

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01610	Continued From page 31 April 15, 2025. R1's service plan dated April 14, 2025, indicated R1 received services to include activity assistance, ambulation, bathing, behavior management, medication reminder, medication administration and medication setup. R1's medication administration record (MAR) dated April 2025, indicated licensee's staff administered medications to R1 on the evening of April 15, 2025. R1's Admission assessment completed by the RN was dated April 24, 2025, nine days after R1 started receiving services. The assessment was not completed prior to the initiation of services on April 15, 2025. R2 R2's diagnoses included Lewy body dementia (progressive form of dementia that affects thinking, reasoning, and information processing). R2's Resident Contract was signed on June 27, 2025. R2's service plan dated June 27, 2025, indicated R2 received services to include activity assistance, ambulation, bathing, bedmaking, dressing, grooming, incontinence care, behavior management, safety checks and medication administration. R2's MAR dated June 2025, indicated the licensee's staff administered medications to R2 on the afternoon of June 27, 2025. R2's Admission assessment completed by the RN was dated June 29, 2025, two days after R2	01610		

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01610	Continued From page 32 started receiving services. The assessment was not completed prior to the initiation of services on June 27, 2025. On July 8, 2025, at 8:38 a.m., clinical nurse supervisor (CNS)-B reviewed R1 and R2's admission assessments and stated the dates on the assessment indicated they were completed after the date of R1 and R2's admission. CNS-B stated R1 and R2's assessments were completed on the date of admission. CNS-B stated the April 24, 2025, assessment for R1 and the June 29, 2025, for R2 was the date that RN marked the assessment as completed. CNS-B stated the electronic health record system is new and did not realize the complete button needed to be selected. The licensee's Resident Assessment and Monitoring policy dated May 2024, indicated a registered nurse shall assess 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. 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.	01620		

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01620	Continued From page 33 (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 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	01620		

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01620	Continued From page 34 of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted timely ongoing nursing assessments not to exceed 14 days from admission 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 potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted on April 15, 2025, with diagnoses that included osteoporosis (a condition in which bones become weak and brittle). R1's service plan dated April 14, 2025, indicated R1 received services to include activity assistance, ambulation, bathing, behavior management, medication reminder, medication administration and medication setup. R1's ongoing nursing assessments were requested. Assessments dated April 24, 2025,	01620		

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01620	Continued From page 35 and May 14, 2025, were provided. The May 14, 2025, assessment was completed 29 days after the date of admission, thus exceeding 14 calendar days. On July 8, 2025, at 8:45 a.m., clinical nurse supervisor (CNS)-B stated R1's assessment was not completed within 14 calendar days from the date of R1's admission. CNS-B stated he thought the assessment had to be completed within 30 days, not 14 days. The licensee's Resident Assessment and Monitoring policy dated May 2024, indicated resident reassessment and monitoring shall be conducted no more than 14 calendar days after initiation of services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman	01640		

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01640	Continued From page 36 for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a written service plan was signed and revised to reflect the current services provided for the licensee's two residents (R1 and 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: On July 7, 2025, at 10:10 a.m. during the entrance conference, clinical nurse supervisor (CNS)-B stated the licensee provided medication management services and setup medications for the licensee's two residents. R1 R1 was admitted on April 15, 2025, with diagnoses that included osteoporosis (a condition in which bones become weak and brittle).	01640		

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01640	Continued From page 37 R1's service plan dated April 14, 2025, indicated R1 received services to include activity assistance, ambulation, bathing, behavior management, medication reminder, medication administration and medication setup. R1's service plan was not signed by the licensee. R2 R2 was admitted on June 27, 2025, with diagnoses that included Lewy body dementia (progressive form of dementia that affects thinking, reasoning, and information processing). R2's service plan dated June 27, 2025, indicated R2 received services to include activity assistance, ambulation, bathing, bedmaking, dressing, grooming, incontinence care, behavior management, safety checks and medication administration. R2's service plan did not include medication setup and was not signed by the licensee. On July 8, 2025, at 8:11 a.m., CNS-B reviewed R1 and R2's service plans and stated they were not signed by the licensee. CNS-B provided an updated service plan dated July 7, 2025, for R2 which did include medication setup. However, this service plan was not signed by R2 or the licensee. The licensee's Service Plan policy, undated, indicated the service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	01640		

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01640	Continued From page 38 (21) days	01640		
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 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	01700		

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01700	Continued From page 39 all required content for the licensee's two residents (R1 and R2) 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 potential to affect a large portion or all of the residents). The findings include: During the entrance conference on July 7, 2025, at 10:10 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to the residents. R1 R1 was admitted on April 15, 2025, with diagnoses that included osteoporosis (a condition in which bones become weak and brittle). R1's service plan dated April 14, 2025, indicated R1 received services to include medication reminder, medication administration and medication setup. R1's signed prescriber orders dated April 22, 2025, include the following medications: -levothyroxine 0.075 milligrams (mg); take two tablets by mouth on an empty stomach (thyroid) -Calcium 600 mg/Vitamin D 400 international units (IU); administer one tablet by mouth daily (osteoporosis) -omeprazole 20 mg; administer one capsule by mouth one hour before meal (reflux)	01700		

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01700	Continued From page 40 -atorvastatin 10 mg; administer one tablet by mouth daily (cholesterol) -Vitamin Mineral Supplement; Administer one veggie soft gel by mouth with food (supplement) Further, R1's signed prescriber orders did not include an order for teriparatide injection. R1's Medication Administration Record (MAR) dated April 2025, indicated R1 first received medications administered by staff on April 15, 2025; however, R1's signed prescriber orders were not received until April 22, 2025, and R1's Medication Assessment was not completed until April 24, 2025. R2 R2 was admitted on June 27, 2025, with diagnoses that included Lewy body dementia (progressive form of dementia that affects thinking, reasoning, and information processing). On July 7, 2025, at 12:11 p.m., the surveyor observed unlicensed personnel (ULP)-E administer medications to R2. R2's service plan dated June 27, 2025, indicated R2 received services to include medication administration. R2's service plan did not include medication setup. R2's signed prescriber orders dated July 1, 2025, included the following medications: -alfuzosin hydrochloride 10 mg; take one tablet by mouth daily (prostate) -Ashwagandha 1400 mg; take one tablet by mouth daily (supplement) -docusate sodium 100 mg; take one capsule by mouth twice daily (constipation) -donepezil 10 mg; take 1.5 tablets x 30 days, then one tablet by mouth daily (dementia)	01700		

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	40415	A. BUILDING: _____ B. WING _____	07/08/2025

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01700	Continued From page 41 -ferrous sulfate 325 mg; take one tablet by mouth daily (supplement) -Osteo Bioflex; give one tablet by mouth once daily (supplement) -polyethylene glycol; take 17 grams by mouth daily (constipation) -Preservision Areds 2; take one soft gel by mouth daily (eye health) -trazodone 100 mg; take one tablet by mouth at bedtime (sleep) -Vitamin D3 100 IU; take one tablet by mouth daily (supplement) -acetaminophen 325 mg; take two tablets by mouth every four hours as needed (pain) R2's MAR dated June 2025, indicated R2 first received medications administered by staff on June 27, 2025; however, R2's signed prescriber orders were not received until July 1, 2025. R2's record lacked evidence the RN conducted a face-to-face review of all medications R2 was known to be taking to include indications for use, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. In addition, R2's record 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 July 8, 2025, at 8:24 a.m., operations officer (OO)-A stated the licensee did not obtain signed prescriber orders prior to the start of medication management services. OO-A and CNS-B stated new residents were asked what medications they were currently taking and would enter those medications into the electronic health record (EHR). Once the medications were entered into the EHR the licensee would print that medication	01700		

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01700	Continued From page 42 list and fax it to the resident's primary care provider (PCP) requesting that the PCP review and sign the medication list. OO-A stated R1's assessment was marked complete after the R1 started receiving medication management services. CNS-B reviewed R2's record and stated it lacked the medication assessment with required content as listed above. CNS-B stated the EHR system was new and was still learning how to use it to ensure the required content for medication assessments were completed accurately. The licensee's Monitoring, Verification, and Evaluating Medication Use policy dated May 2024, indicated the RN shall conduct an initial face-to-face assessment of the resident's mediation regimen, including a review of all prescribed, over-the-counter medications, and supplements. Document the resident's medical history, known allergies, contraindication, and any previous adverse medication reactions. Document interventions to address any contraindications, adverse reactions, allergies. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management	01730		

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01730	Continued From page 43 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; (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:	01730		

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01730	Continued From page 44 Based on interview and record review, the licensee failed to develop an individualized medication management plan with the required content for the licensee's two residents (R1 and R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted on April 15, 2025, with diagnoses that included osteoporosis (a condition in which bones become weak and brittle). R1's service plan dated April 14, 2025, indicated R1 received services to include medication reminder, medication administration and medication setup. R1's signed prescriber orders dated April 22, 2025, include the following medications: -levothyroxine 0.075 milligrams (mg); take two tablets by mouth on an empty stomach (thyroid) -Calcium 600 mg/Vitamin D 400 international units (IU); administer one tablet by mouth daily (osteoporosis) -omeprazole 20 mg; administer one capsule by mouth one hour before meal (reflux) -atorvastatin 10 mg; administer one tablet by mouth daily (cholesterol) -Vitamin Mineral Supplement; Administer one	01730		

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01730	Continued From page 45 veggie soft gel by mouth with food (supplement) R1's record lacked a signed prescriber order for teriparatide injection. R1's medication management plan dated May 14, 2025, lacked the following required content: -a description of storage of medications based on the resident's needs and preferences , risk of diversion, and consistent with the manufacturer's directions; -identification of medication management tasks that may be delegated to the unlicensed personnel; -procedures for staff notifying registered nurse or appropriate licensed health professional when a problem arises with medication management services; and -any resident-specific requirements relating to documenting medication administration, verification that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions R2 R2 was admitted on June 27, 2025, with diagnoses that included Lewy body dementia (progressive form of dementia that affects thinking, reasoning, and information processing). R2's service plan dated June 27, 2025, indicated R2 received services to include activity assistance, ambulation, bathing, bedmaking, dressing, grooming, incontinence care, behavior management, safety checks and medication administration. R2's service plan did not include medication setup and was not signed by the licensee. R2's signed prescriber orders dated July 1, 2025,	01730		

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01730	Continued From page 46 included the following medications: -alfuzosin hydrochloride 10 mg; take one tablet by mouth daily (prostate) -Ashwagandha 1400 mg; take one tablet by mouth daily (supplement) -docusate sodium 100 mg; take one capsule by mouth twice daily (constipation) -donepezil 10 mg; take 1.5 tablets x 30 days, then one tablet by mouth daily (dementia) -ferrous sulfate 325 mg; take one tablet by mouth daily (supplement) -Osteo Bioflex; give one tablet by mouth once daily (supplement) -polyethylene glycol; take 17 grams by mouth daily (constipation) -Preservision Areds 2; take one soft gel by mouth daily (eye health) -trazodone 100 mg; take one tablet by mouth at bedtime (sleep) -Vitamin D3 100 IU; take one tablet by mouth daily (supplement) -acetaminophen 325 mg; take two tablets by mouth every four hours as needed (pain) R2's medication management plan dated June 29, 2025, lacked the following required content: -a description of storage of medications based on the resident's needs and preferences , risk of diversion, and consistent with the manufacturer's directions; -documentation of specific resident instructions relating to the administration of medications; -identification of medication management tasks that may be delegated to the unlicensed personnel; -procedures for staff notifying registered nurse or appropriate licensed health professional when a problem arises with medication management services; and -any resident-specific requirements relating to	01730		

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01730	Continued From page 47 documenting medication administration, verification that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions On July 8, 2025, at 8:20 a.m., clinical nurse supervisor (CNS)-B reviewed R1 and R2's individualized medication plans and stated the plans did not include the required content as listed above. CNS-S stated the electronic monitoring system they use to complete the assessments is new and he continues to learn how to use it to ensure all required content is addressed in R1 and R2's assessments. The licensee's Monitoring, Verification and Evaluating Medication Use policy dated May 2024, indicated it was the responsibility of the licensee to monitor resident's medication regimens, assess for any side effects or adverse reactions, and evaluate the overall effectiveness of prescribed medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
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	01790		

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01790	Continued From page 48 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, 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	01790		

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01790	Continued From page 49 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-E and ULP-G) providing medications to residents for 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 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: ULP-E ULP-E was hired on June 7, 2025, to provide direct care and services to the facility's residents. ULP-E's employee record lacked documentation	01790		

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01790	Continued From page 50 of training and competencies for unplanned time away when the RN was not available. ULP-G ULP-G was hired on April 9, 2025, to provide direct care and services to the facility's residents. ULP-G's employee record lacked documentation of training and competencies for unplanned time away when the RN was not available. On July 8, 2025, at 11:05 a.m., clinical nurse supervisor (CNS)-B stated ULP-E and ULP-G's employee records lacked evidence of being trained and competency tested for unplanned time away. CNS-B stated the same training documents were used for all staff. CNS-B stated the licensee was in the process of updating their training program, which would include unplanned time away. The licensee's Medications for Leave of Absence policy dated May 2024, indicated for unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving mediations to residents. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01820 SS=F	144G.71 Subd. 13 Prescriptions There must be a current written or electronically	01820		

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01820	Continued From page 51 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 current written or electronically recorded prescriptions were obtained for all medications the provider managed for the licensee's two residents (R1 and R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted on April 15, 2025, with diagnoses that included osteoporosis (a condition in which bones become weak and brittle). On July 8, 2025, at 9:08 a.m., the surveyor observed R1 self-administer her teriparatide injection. R1's service plan dated April 14, 2025, indicated R1 received services to include medication reminders, medication administration, and medication setup. R1's service plan was not	01820		

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01820	Continued From page 52 signed by the licensee. R1's Medication Administration Record (MAR) dated April 2025, indicated R1 first received medications administered by staff on April 15, 2025; however, R1's signed prescriber orders were not received until April 22, 2025. R1's signed prescriber orders dated April 22, 2025, include the following medications: -levothyroxine 0.075 mg; take two tablets by mouth on an empty stomach (thyroid) -Calcium 600 mg/Vitamin D 400 international units (IU); administer one tablet by mouth daily (osteoporosis) -omeprazole 20 mg; administer one capsule by mouth one hour before meal (reflux) -atorvastatin 10 mg; administer one tablet by mouth daily (cholesterol) -Vitamin Mineral Supplement; Administer one veggie soft gel by mouth with food (supplement) R1's Medication Administration Record (MAR) dated July 2025, included the following medications: -levothyroxine 0.075 milligrams (mg); take two tablets by mouth on an empty stomach (thyroid) -teriparatide 620 micrograms (mcg)/2.81 milliliters (ml); Assist client with set up. Client may self-administer daily (osteoporosis) -Calcium 600 mg/Vitamin D 400 IU; administer one tablet by mouth daily (osteoporosis) -omeprazole 20 mg; administer one capsule by mouth one hour before meal (reflux) -atorvastatin 10 mg; administer one tablet by mouth daily (cholesterol) -Vitamin Mineral Supplement; Administer one veggie soft gel by mouth with food (supplement) R1's signed prescriber orders did not include an	01820		

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01820	Continued From page 53 order for the teriparatide injection. On July 8, 2025, at 1:23 p.m., clinical nurse supervisor (CNS)-B stated the licensee had requested a prescription for the teriparatide injection from R1's provider, however they had not received it yet. R2 R2 was admitted on June 27, 2025, with diagnoses that included Lewy body dementia (progressive form of dementia that affects thinking, reasoning, and information processing). R2's service plan dated June 27, 2025, indicated R2 received services to include activity assistance, ambulation, bathing, bedmaking, dressing, grooming, incontinence care, behavior management, safety checks and medication administration. R2's service plan did not include medication setup and was not signed by the licensee. R2's MAR dated June 2025, indicated R2 first received medications administered by staff on June 27, 2025; however, R2's signed prescriber orders were not received until July 1, 2025. R2's signed prescriber orders dated July 1, 2025, included the following medications: -alfuzosin hydrochloride 10 mg; take one tablet by mouth daily (prostate) -Ashwagandha 1400 mg; take one tablet by mouth daily (supplement) -docusate sodium 100 mg; take one capsule by mouth twice daily (constipation) -donepezil 10 mg; take 1.5 tablets x 30 days, then one tablet by mouth daily (dementia) -ferrous sulfate 325 mg; take one tablet by mouth daily (supplement)	01820		

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CULTIVATE CARE LLC	4333 MEDARY AVENUE EAGAN, MN 55122

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01820	Continued From page 54 -Osteo Bioflex; give one tablet by mouth once daily (supplement) -polyethylene glycol; take 17 grams by mouth daily (constipation) -Preservision Areds 2; take one soft gel by mouth daily (eye health) -trazodone 100 mg; take one tablet by mouth at bedtime (sleep) -Vitamin D3 100 IU; take one tablet by mouth daily (supplement) -acetaminophen 325 mg; take two tablets by mouth every four hours as needed (pain) On July 8, 2025, at 8:24 a.m., operations officer (OO)-A stated the licensee did not obtain signed prescriber orders prior to the start of medication management services. OO-A and CNS-B stated new residents were asked what medications they were currently taking and would enter those medications into the electronic health record (EHR). Once the medications were entered into the EHR, the licensee would print that medication list and fax it to the resident's primary care provider (PCP) requesting that the PCP review and sign the medication list. The licensee's Medication Orders policy dated May 2024, indicated it is the policy of [licensee] to request and receive medication prescriptions for medications and biologicals administered to residents that receive medication management services. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40415	A. BUILDING: _____ B. WING _____	07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CULTIVATE CARE LLC	4333 MEDARY AVENUE EAGAN, MN 55122

(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
03090	Continued From page 55	03090		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the required notice was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all current residents, staff, and any visitors of the facility. This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The finding include: On July 7, 2025, at approximately 9:15 a.m. upon arriving at the establishment, an observation outside the front entrance, or just inside the front entrance, lacked the required posting for electronic monitoring devices. On July 7, 2025, at 2:47 p.m., operations officer (OO)-A stated the licensee did not have a posting	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40415	A. BUILDING: _____ B. WING _____	07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CULTIVATE CARE LLC	4333 MEDARY AVENUE EAGAN, MN 55122

(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
03090	Continued From page 56 regarding electronic monitoring. OO-A stated she didn't think it needed to be posted unless they used electronic monitoring devices, which the licensee did not. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Cultivate Care LLC
4333 Medary Ave
Eagan, MN 55122
Dakota County
Parcel:

Phone:

License Info

License: HFID 40415

Risk:
License:
Expires on:
CFPM: KRISTINA NGO
CFPM #: CFPM-58430; Exp: 04/15/2028

Inspection Info

Report Number: F1005251047
Inspection Type: Full - Single
Date: 7/8/2025 Time: 11:00:39 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 1
Total Priority 2 Orders: 2
Total Priority 3 Orders: 2
Delivery:

! New Order: 3-500B Microbial Control: hot and cold holding
3-501.16A2 *Priority Level: Priority 1 CFP#: 22*
MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.
COMMENT: TCS FOODS IN THE KITCHEN REFRIGERATOR WERE 45-46 DEGREES F. REFRIGERATOR WAS TURNED DOWN SEVERAL DEGREES, MONITOR FOODS TO ENSURE THEY ARE 41 DEGREES F OR BELOW.
Comply By: 7/8/2025 Originally Issued On: 7/8/2025

New Order: 4-200 Equipment Design and Construction
4-201.11GMN *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0506G Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.
COMMENT: LARGE CONTAINERS OF LEFTOVERS FROM LUNCH WERE OBSERVED COOLING IN THE REFRIGERATOR IN CLOSED CONTAINERS. LIDS WERE REMOVED AND FOOD WAS PLACED IN THE FREEZER TO COOL PROPERLY. DISCUSSED THAT IN THE FUTURE LEFTOVERS MUST BE DISCARDED TO AVOID IMPROPER COOLING.
Comply By: 7/8/2025 Originally Issued On: 7/8/2025

New Order: 4-200 Equipment Design and Construction
4-204.112A *Priority Level: Priority 3 CFP#: 36*
MN Rule 4626.0620A Provide a temperature measuring device located in the warmest part of mechanically refrigerated units and coolest part of hot food storage units that are capable of measuring air temperature or a simulated product temperature.
COMMENT: THERE IS NO AMBIENT THERMOMETER IN THE REFRIGERATOR, AND FOOD WAS MUCH WARMER THAN THE IN-LINE DIGITAL DISPLAY WAS READING. PROVIDE A THERMOMETER IN THE WARMEST AREA OF THE REFRIGERATOR.
Comply By: 7/15/2025 Originally Issued On: 7/8/2025

New Order: 4-300 Equipment Numbers and Capacities
4-302.12A *Priority Level: Priority 2 CFP#: 36*
MN Rule 4626.0705A Provide a readily accessible food temperature measuring device to ensure attainment and maintenance of food temperatures.
COMMENT: THERE IS NO FOOD THERMOMETER ON SITE. PROVIDE A FOOD THERMOMETER TO MONITOR COLD HOLDING TEMPERATURES IN THE FRIDGE AND COOKING TEMPERATURES.
Comply By: 7/15/2025 Originally Issued On: 7/8/2025

New Order: 4-300 Equipment Numbers and Capacities
4-302.13B *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.
COMMENT: THERE IS NO DEVICE ON SITE TO MEASURE THE UTENSIL SURFACE TEMPERATURE IN THE DISH MACHINE. PROVIDE TEMPERATURE STRIPS OR A MAXIMUM REGISTERING THERMOMETER TO VERIFY THAT THE UTENSIL SURFACE TEMPERATURE IS 160 DEGREES F OR ABOVE.

Comply By: 7/15/2025 *Originally Issued On: 7/8/2025*

Food & Beverage General Comment

INSPECTION COMPLETED WITH OWNER AND EMAILED TO HRD NURSING EVALUATOR KASSIE MARKING.

DISCUSSED DATE MARKING, GLOVE USE, COOKING TEMPERATURES, CROSS-CONTAMINATION, AND EMPLOYEE ILLNESS.

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

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 F1005251047 from 7/8/2025

THAO TRINH
OWNER / DIRECTOR

Jessica Davis, REHS
Public Health Sanitarian 3
651-201-3961
jessica.davis@state.mn.us

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

Temperature Observations/Recordings

Establishment Info

Cultivate Care LLC
Eagan
County/Group: Dakota County

Inspection Info

Report Number: F1005251047
Inspection Type: Full
Date: 7/8/2025
Time: 11:00:39 AM

Food Temperature: Product/Item/Unit: BEAN SPROUTS**; Temperature Process:** Cold-Holding
Location: LG REFRIGERATOR at 46 Degrees F.
Comment:
Violation Issued?: Yes

Food Temperature: Product/Item/Unit: POT STICKER**; Temperature Process:** Cold-Holding
Location: LG REFRIGERATOR at 46 Degrees F.
Comment:
Violation Issued?: Yes

New Record: Product/Item/Unit: PUDDING**; Temperature Process:** Cold-Holding
Location: LG REFRIGERATOR at 45 Degrees F.
Comment:
Violation Issued?: Yes

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

Sanitizer Observations/Recordings

Establishment Info

Cultivate Care LLC
Eagan
County/Group: Dakota County

Inspection Info

Report Number: F1005251047
Inspection Type: Full
Date: 7/8/2025
Time: 11:00:39 AM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: KITCHEN **Equal To** 165 Degrees F.
Comment:
Violation Issued?: No