Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF PROVISIONAL EXTENSION AND CONDITIONAL LICENSE

Electronically Delivered

April 13, 2026

Licensee
Evergreen Assisted Living Homes, Inc.
7016 Antrim Road
Edina, MN 55439

RE: Provisional Conditional License Number 418239
Health Facility Identification Number (HFID) 40475
Project Number SL40475015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 12, 2026, for the purpose of assessing compliance with state licensing statutes. Based on the survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.16, Subd. 3(b)(2), MDH is extending the provisional license for 90-days and applying conditions necessary to bring the facility into substantial compliance. The provisional license extension and conditions are due to expire **July 12, 2026**.

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

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

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

Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

MDH may assess fines based on the level and scope of the orders outlined below. The total amount of **potential** fines that may be assessed related to these correction orders is $1,000.00. **MDH is not imposing these fines against your provisional license at this time.**

St - 0 - 1290 - 144g.90 Subdivision 1 - Background Studies Required - $1,000.00

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the provisional licensee must document actions taken to comply with the correction orders and immediately correct any reissued orders outlined on the state form; however, plans of correction are not required to be submitted for approval. **If corrections are not made, MDH may impose fines as described above and in accordance with Minnesota Statutes 144G.**

The correction order documentation should include the following:

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

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

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

CONDITIONAL LICENSE ISSUED:
MDH will issue Evergreen Assisted Living Homes, Inc. a conditional provisional assisted living facility license for 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if Evergreen Assisted Living Homes, Inc. is in substantial compliance.

The following conditions apply on the conditional provisional assisted living facility license:

a. **No new substantiated maltreatment allegations:** If any new investigations begin in the conditional provisional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the provisional license.

b. **No new admissions:** Evergreen Assisted Living Homes, Inc. will not admit any new residents under its conditional provisional assisted living facility license until MDH removes the "no new admissions" condition. Evergreen Assisted Living Homes, Inc. must provide the Department:

    i. A list of the names and birthdates of any individuals Evergreen Assisted Living Homes, Inc. is currently in the process of admitting. These individuals will be able to continue the admittance process.

    ii. A list of all current residents including:
        1. Name and birthdate of each resident
        2. Current payment source for services
        3. If Elderly Waiver, the name and contact information of the care coordinator/case manager
        4. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative

c. **Monitoring visits:** MDH may make unannounced monitoring visits to assess the progress of Evergreen Assisted Living Homes, Inc. to correct the violations cited during the survey as well as to determine the overall practice of Evergreen Assisted Living Homes, Inc. in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive provisional licensed assisted living services. The OOLTC will share their findings with MDH.

d. **Follow-up survey:** At the time of the follow-up survey, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the provisional license if MDH identifies any level 3 or 4 violations or widespread care related violations.

e. **Corrective Action Plan:** Evergreen Assisted Living Homes, Inc. will develop and work within a corrective action plan (CAP). The CAP is a working document that includes at least the following information:
    i. A statement of the concern
    ii. A description of what will happen to correct the concern
    iii. A target date for when each correction will be complete
    iv. Who is responsible to make sure it happens

v. Current status of correction work
vi. Description of a plan to monitor and ensure ongoing substantial compliance for each corrected order

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL PROVISIONAL LICENSE PERIOD:
MDH will determine if Evergreen Assisted Living Homes, Inc. is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional provisional license period. If MDH determines Evergreen Assisted Living Homes, Inc. is in substantial compliance on the follow up survey, MDH will remove the conditions and grant the assisted living facility license to Evergreen Assisted Living Homes, Inc.. If MDH determines Evergreen Assisted Living Homes, Inc. is not in substantial compliance, MDH may deny the license pursuant to Minn. Stat. § 144G.16, Subd. 3 (b) (2).

REQUEST FOR RECONSIDERATION:
Pursuant to Minn. Stat. §144G.16, Subd. 4, if a provisional licensee whose assisted living facility license has been denied, or extended with conditions, disagrees with the action taken against the provisional license under this section, the provisional licensee may request a reconsideration no later than 15 calendar days after provisional licensee receives notice of the action. **This is your only ability to request a reconsideration under this enforcement action.**

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

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 Casey DeVries directly at: 651-201-5917 or email at: Casey.DeVries@state.mn.us.

Sincerely,

Rick Michals

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40475	A. BUILDING: _____ B. WING _____	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN ASSISTED LIVING HOME INC	7016 ANTRIM ROAD EDINA, MN 55439

(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: SL40475015-0 On March 9, 2026, through March 12, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were four residents all of whom received services under the Provisional Assisted Living Facility license. An immediate correction order was identified on March 9, 2026, issued for SL40475015-0, tag identification 1290. During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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

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0 480	Continued From page 2 existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated March 10, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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0 480	Continued From page 3 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services (a) All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not require any resident to include and pay for meals as a part of their assisted living package fee. This had the potential to affect all residents of the facility. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when	0 485		

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0 485	Continued From page 4 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 blank Admission Agreement, read, "For an established Daily Rate (as further defined below), Facility will furnish you with the following "Basic Care Services:" - nursing and personal care services - lodging - meals" The contract included verbiage to require residents to pay for their meals as part of their assisted living package fee and lacked the option to opt out of the meal plan. On March 10, 2026, at 10:15 a.m., owner (O)-F stated the licensee did not charge separately for meals, but residents could choose not to have meals prepared by the licensee. O-F stated another licensee owned by the parent company was issued a citation on the issue noted above and they believed another employee was working on fixing the issue in the contract. On March 10, 2026, at 1036 a.m., vice president (VP)-E stated the blank contract was used by the licensee for all residents who resided in the assisted living facility. VP-E stated there was no verbiage in the contract to opt out of receiving meals. On March 10, 2026, at 12:46 p.m., VP-E stated they corrected the blank contract to have an option to opt out of receiving meals. The surveyor observed the new blank contract and observed the corrections were made. Although the blank contract had been corrected the licensee still	0 485		

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0 485	Continued From page 5 needed to reissue the contract to the current residents residing at the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by:	0 680		

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0 680	Continued From page 6 Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's EPP last reviewed on October 9, 2025, lacked evidence of the following required content: - quarterly review of the missing resident plan; and - roles under 1135 waiver declared by secretary. On March 10, 2026, at 1:36 p.m., owner (O)-F stated the missing resident plan was reviewed last in October 2025, and the licensee reviewed the plan annually. O-F stated they did not know the missing resident plan needed to be reviewed quarterly. In addition, O-F stated the EPP did not address roles under waiver 1135. O-F stated they were not familiar with the waiver. The licensee's Emergency Action Plan (EAP) Policy revised April 2024 indicated the purpose of the EAP was to coordinate and streamline employee and company procedures in the event of an emergency in the workplace. There would be fewer and less severe injuries among	0 680		

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0 680	Continued From page 7 employees as well as less damage to the facility during emergencies when there was a well-developed emergency plan and appropriate employee education. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice	0 810		

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0 810	Continued From page 8 per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated 3-12-26, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 940 SS=C	144G.50 Subd. 2 (e; 5-7) Contract information	0 940		

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0 940	Continued From page 9 (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on interview and record review, the	0 940		

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0 940	Continued From page 10 licensee failed to execute a written assisted living contract with all required content. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's Admission Agreement included a section titled Public and Private Third - Party Payment Programs. The section read, "At this time it is important that you discuss with Facility your participation in any HMO, PPO, or Third Party Insurance which may cover some or all of the Basic Care Services or Special Services. Facility participates in the Minnesota Medical Assistance (Medicaid) Program and the Medicare Program. Facility does not participate in Veterans Administration programs. Facility may participate in some other public and /or private third party payment programs and we will provide you with a current listing and level of facility participation at your request. We will also inform you of applicable changes in this listing during your stay. You are responsible for applying for and maintaining eligibility for any such third-party payment programs." The licensee's contract did not provide an accurate description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49. In addition, the contract lacked a description of the facility's policies related to housing support program under chapter 256I.	0 940		

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	40475	A. BUILDING: _____ B. WING _____	03/12/2026

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0 940	Continued From page 11 On March 10, 2026, at 1036 a.m., vice president (VP)-E stated the blank contract was used by the licensee for all residents who resided in the assisted living facility. VP-E stated the contract was used by multiple licensees the company owned and then the contract was customized to the specific licensee. VP-E stated the licensee did not participate in the housing support program however, they do not charge for rent if they are on a waivered service because the resident would not have money to pay for rent. VP-E stated the licensee took a loss for payment for not billing for rent. The surveyor inquired if the licensee had a limit on the number of residents they would take on waivered services. VP-E stated the company had properties that accepted waivers and some that did not. The surveyor inquired if this licensee had a limit. VP-E stated the licensee did not accept waivered services and only accepted private pay at the facility. On March 10, 2026, at 11:25 a.m., VP-E stated they were not aware of all of the required content to address medical assistance waivers and customized living services. On March 10, 2026, at 12:46 p.m., VP-E stated they corrected the blank contract and customized the public assistance section. The surveyor observed the new blank contract and observed the corrections were made. Although the blank contract had been corrected, the licensee still needed to reissue the contract to the current residents residing at the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 940		

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0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to include verbatim language giving residents the right to identify a designated representative. This had the potential to affect all residents.	0 950		

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0 950	Continued From page 13 This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's blank Admission Agreement lacked the opportunity to designate a representative and the verbatim "right to designate a representative for certain purposes" notice. On March 10, 2026, at 1036 a.m., vice president (VP)-E stated the blank contract was used by the licensee for all residents who resided in the assisted living facility. On March 10, 2026, at 11:25 a.m., VP-E stated the licensee did not have a document that discussed designated representative. VP-E stated the licensee discussed with the residents the right to have a designated representative during the admission process. The surveyor reviewed the statue with VP-E and VP-E stated they were not aware of the sperate notice discussing designated representative or the specific verbiage. VP-E stated when they started employment with the licensee, they were told the contract was obtained from a third party and they believed the document met the required content since it was received from a third party. On March 10, 2026, at 12:46 p.m., VP-E stated they corrected the blank contract to include the designated representative notice. The surveyor	0 950		

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0 950	Continued From page 14 observed the new blank contract and observed the corrections were made. Although the blank contract had been corrected the licensee still needed to reissue the contract to the current residents residing at the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950		
01290 SS=G	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based observation, interview, and record review, the licensee failed to ensure a background study was submitted and a clearance letter was received as required for two of 14 employees (unlicensed personnel (ULP)-A, ULP-B).	01290		

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01290	Continued From page 15 This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at 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-A ULP-A was hired on November 20, 2025, to provide assisted living services to residents. ULP-A's paycheck paid on March 6, 2026, indicated ULP-A worked 40 hours regular pay and 24.67 hours in overtime. ULP-B ULP-B was hired on November 8, 2024, to provide assisted living services to residents. On March 9, 2026, at 1:02 p.m., the surveyor observed ULP-B escorting R1 and R4 to the upper level of the facility. ULP-B's paycheck paid on March 6, 2026, indicated ULP-B worked 39.04 hours. On March 9, 2026, at 12:47 p.m., the surveyor compared the licensee's staff list to the licensee's provided NETStudy 2.0 roster (web-based system used by the Minnesota Department of Human Services (DHS) to submit and process background study requests). The surveyor did not observe ULP-A or ULP-B listed on the NETStudy 2.0 roster for HFID# 40475. On March 9, 2026, at 12:50 p.m., licensed	01290		

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01290	Continued From page 16 assisted living director (LALD)-D opened their NETStudy 2.0 rosters on their computer with the surveyor present and stated ULP-A and ULP-B were not located on their company rosters or facility roster. LALD-D stated both ULP-A and ULP-B provided resident care and worked independently with residents. On March 9, 2026, at 1:47 p.m., LALD-D stated their process was upon hire they collected information from applicants and completed a background study on NETStudy 2.0 before the employee was allowed to work on the floor in the facility. LALD-D stated ULP-B was a previous employee of the company who was rehired, and they believed that was how their background study was missed. LALD-D stated they were unable to determine how ULP-A's background study was not submitted. On March 9, 2026, at approximately 2:55 p.m., LALD-D stated ULP-A and ULP-B were both hired to work for the parent company. LALD-D stated employees were hired for all facility locations. In addition, LALD-D stated ULP-A was just affiliated to the licensee's HFID and ULP-B had an appointment for fingerprinting tomorrow at 9:00 a.m. The licensee's Employee Background Check Policy dated March 2024 indicated criminal background checks were required for all people interviewing for positions. The policy indicated the licensee would follow all laws, but the policy did not address the requirement to conduct a background study utilizing DHS. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290		

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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 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	01530		

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01530	Continued From page 18 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 provide two hours of initial training for employees hired prior to July 1, 2025, related to mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8) for one of two employees (unlicensed personnel (ULP)-G). 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-G was hired on March 2, 2024, to provide assisted living services to residents. ULP-G's employee record included an undated EduCare (a training software program) transcript that indicated ULP-G received 45 minutes of training on mental illness on September 27, 2024. In addition, it included a learning management system (LMS) (a training software program) transcript dated March 10, 2025, to March 11, 2026, that did not include any mental illness training hours. ULP-G's employee record lacked one hour 15 minutes of initial mental illness and de-escalation training.	01530		

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01530	Continued From page 19 On March 10, 2026, at 2:47 p.m., owner (O)-F stated that when ULP-G was hired mental health training was not required. O-F stated the licensee changed training software programs from EduCare to LMS when the new regulation on mental health came out and the licensee purchased more courses related to mental health. O-F stated if the LMS transcript did not include the mental health courses then ULP-G did not receive them. O-F stated all employees listed as home health aides received the two hours of initial mental health and de-escalation training when the new regulation took effect. O-F stated ULP-G was promoted and they believed the position they entered ULP-G into the LMS system may not have triggered the mental health courses to be added to ULP-G's account. On March 11, 2026, at 3:08 p.m., clinical nurse supervisor (CNS)-C stated mental health training was completed on LMS, and training was assigned to the employee by licensed assisted living director (LALD)-D. The licensee's undated Mental Health Training Policy indicated supervisors of direct-care staff members must have at least two hours of initial training on mental illness and de-escalation within 120 working hours and direct staff must have two hours of initial training and mental illness and de-escalation withing 160 working hours. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		

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01610	Continued From page 20	01610		
01610 SS=D	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods 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 a conduct a nursing assessment by a registered nurse (RN) of the physical and cognitive needs for one of two residents (R2) on or before the admission date. 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).	01610		

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01610	Continued From page 21 The findings include: R2 was admitted to the licensee on January 7, 2026, and began receiving assisted living services. R2's diagnoses included spinal stenosis, rotator cuff tear, anemia, edema, long term use of steroids, asthma, morbid obesity, intervertebral disc degeneration, osteoporosis, and traumatic brain injury. R2's Service Plan - Modification dated March 10, 2026, completed during the survey, indicated R2 received assistance with activities, appointments, bed mobility, showers, housekeeping, dressing, equipment care, mobility, grooming, toileting, laundry, meals, medication administration, nail care, positioning, vital sign monitoring, safety checks, skin care, socialization, supervision of wound care, therapeutic exercises, transfers, and transportation. R2's Assessment History by Client dated March 9, 2026, indicated a preadmission assessment and admission assessment completed November 26, 2025, and two clinical updates completed on December 5, 2025, and December 19, 2025. R2's medical record lacked an initial assessment completed by an RN before or on the date of admission to the licensee. On March 10, 2026, at 9:48 a.m., clinical nurse supervisor (CNS)-C stated assessments were completed prior to admission, on the day of admission, day 14, and ongoing every 90 days or with change of condition like hospitalization or starting hospice care. CNS-C stated a transfer from another licensee would be like a new admission to the facility however, they had	01610		

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01610	Continued From page 22 transferred multiple residents from another facility owned by the same company for a temporary transfer and in that case, they just transferred over the electronic medical record. The surveyor inquired why CNS-C did not complete an initial assessment on R2. CNS-C stated they did not complete another assessment because R2 was transferred from a different licensee within their company. The surveyor inquired if they would complete an initial assessment with a transfer from another licensee the company owned. CNS-C stated no because the residents were still within their company. The licensee's undated Service Police [sic] and Procedure policy indicated "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. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01610		
01640 SS=D	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	01640		

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01640	Continued From page 23 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 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 finalize a current written service plan that included a signature or other authentication by the facility and by the resident documenting an agreement on the services to be provided for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted to the licensee on January 7, 2026, and began receiving assisted living services.	01640		

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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
01640	Continued From page 24 R2's diagnoses included spinal stenosis, rotator cuff tear, anemia, edema, long term use of steroids, asthma, morbid obesity, intervertebral disc degeneration, osteoporosis, and traumatic brain injury. R2's Service Plan - Modification dated December 3, 2025, indicated R2 received assistance with activities, appointments, bed mobility, showers, housekeeping, dressing, mobility, grooming, toileting, laundry, meals, medication administration, nail care, positioning, vital sign monitoring, safety checks, skin care, supervision of wound care, transfers, and transportations. The document indicated the service plan was created by a different licensee within the same company and was completed prior to R2's admission to the licensee. R2's Service Plan - Modification dated March 10, 2026, completed during the survey, indicated R2 received assistance with activities, appointments, bed mobility, showers, housekeeping, dressing, equipment care, mobility, grooming, toileting, laundry, meals, medication administration, nail care, positioning, vital sign monitoring, safety checks, skin care, socialization, supervision of wound care, therapeutic exercises, transfers, and transportation. On March 10, 2026, at 10:22 a.m., clinical nurse supervisor (CNS)-C stated they created a service plan in Residex (a documenting software) for R2, and they attempted to have R2 sign the document on December 19, 2025 (prior to admission to licensee). CNS-C stated they were now working with R2's power of attorney (POA) on multiple documents however, they had reviewed the services they provided to R2 with	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40475	A. BUILDING: _____ B. WING _____	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN ASSISTED LIVING HOME INC	7016 ANTRIM ROAD EDINA, MN 55439

(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
01640	Continued From page 25 the POA. The surveyor requested documentation of attempts to have R2 or R2's POA sign the service plan since admitting to the licensee. CNS-C stated they did not have documentation of attempts to complete the service plan prior to the survey initiation however, they did have documentation of the service plan being sent via DocuSign on March 9, 2026 (during the survey). The licensee's undated Service Police [sic] and Procedure policy indicated no later than 14 calendar days after the date that services were first provided, an "assisted living facility" shall finalize a current written service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility;	01650		

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	40475	A. BUILDING: _____ B. WING _____	03/12/2026

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EVERGREEN ASSISTED LIVING HOME INC	7016 ANTRIM ROAD EDINA, MN 55439

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01650	Continued From page 26 (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included all required content for three of three residents (R1, R2, R5). 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 to the licensee on January 23, 2026, and began receiving assisted living services on January 27, 2026. R1's diagnoses included edema, heart failure, altered mental status, chronic obstructive pulmonary disease (COPD), major depression,	01650		

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01650	Continued From page 27 bipolar, encephalopathy, narcotic dependence, and diabetes type 2 (DM2). R1's Service Plan - Modification signed January 27, 2026, indicated R1 received assistance with activities, ambulation, appointment, bathing, bed mobility, dressing, housekeeping, blood glucose monitoring, mobility, grooming, laundry, medication administration, nail care, vital sign monitoring, safety check, socialization, supervision of wound care, and transportation. R2 R2 was admitted to the licensee on January 7, 2026, and began receiving assisted living services. R2's diagnoses included spinal stenosis, rotator cuff tear, anemia, edema, long term use of steroids, asthma, morbid obesity, intervertebral disc degeneration, osteoporosis, and traumatic brain injury. R2's Service Plan - Modification dated March 10, 2026, completed during the survey, indicated R2 received assistance with activities, appointments, bed mobility, showers, housekeeping, dressing, equipment care, mobility, grooming, toileting, laundry, meals, medication administration, nail care, positioning, vital sign monitoring, safety checks, skin care, socialization, supervision of wound care, therapeutic exercises, transfers, and transportation. R5 R5 was admitted to the licensee on January 23, 2026, and began receiving assisted living services. R5's diagnoses included intracerebral	01650		

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01650	Continued From page 28 hemorrhage (stroke), anemia, acute respiratory failure, dysphagia, hypertension, obstructive hydrocephalus, and spastic hemiplegia. R5's Service Plan - Modification signed January 27, 2026, indicated R5 received assistance with activities, appointments, bathing, bed mobility, housekeeping, dressing, equipment care, mobility, grooming, toileting, laundry, meals, nail care, positioning, vital sign monitoring, safety checks, skin care, socialization, supervision of wound care, transfers, and transportation. R1, R2, and R5's service plans lacked the following required content: - the schedule and methods of monitoring assessments of the resident; - the schedule and methods of monitoring staff providing services; and - a contingency plan that included the action to be taken if the schedule service could not be provided. On March 10, 2026, at 3:04 p.m., owner (O)-F stated they did not realize their service plan lacked the contents listed above. O-F stated they would contact Residex (a documentation software) to add the required content. On March 11, 2026, at 2:55 p.m., clinical nurse supervisor (CNS)-C stated they were aware the service plan needed to contain the schedule and method of monitoring however, Residex did not have the option in the service plan. CNS-C stated they did conduct supervisions on ULP however they completed them on a paper format that were not connected to the service plan. CNS-C stated supervision method and monitoring was not an option to have on the service plan in Residex. CNS-C stated they were unaware of the service	01650		

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01650	Continued From page 29 plan required a contingency plan. The licensee's undated Service Police [sic] and Procedure policy indicated the service plan must include: - a description of the services to be provided, the fees for service, and the frequency of each service, according to the resident's current assessment and preferences; - the identification of staff or categories of staff who would provide the services; - the schedule and methods of monitoring assessment of the resident; - the schedule and methods of monitoring staff who provided services; and - a contingency plan that included the action to be taken if the scheduled service could not be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication	01730		

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01730	Continued From page 30 management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a current individualized medication management record for each resident to include all required content for one of three residents (R2).	01730		

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01730	Continued From page 31 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted to the licensee on January 7, 2026, and began receiving assisted living services. R2's diagnoses included spinal stenosis, rotator cuff tear, anemia, edema, long term use of steroids, asthma, morbid obesity, intervertebral disc degeneration, osteoporosis, and traumatic brain injury. R2's Service Plan - Modification dated March 10, 2026, completed during the survey, indicated R2 received assistance with activities, appointments, bed mobility, showers, housekeeping, dressing, equipment care, mobility, grooming, toileting, laundry, meals, medication administration, nail care, positioning, vital sign monitoring, safety checks, skin care, socialization, supervision of wound care, therapeutic exercises, transfers, and transportation. On March 10, 2026, at 11:14 a.m., the surveyor observed unlicensed personnel (ULP)-I administer oral medication to R2. R2's Individualized Medication Management Plan dated December 19, 2025, completed prior to admission to the licensee, indicated ULP	01730		

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01730	Continued From page 32 administered R2's medications, the nurse monitored medication supply and reordered as needed (PRN), medications were locked in the medication cabinet, ULP should contact the nurse line for questions or concerns related to medication, and ULP were delegated eye drops, ear drops, inhaler, nasal, oral, nebulizers, rectal, sublingual, topical, and transdermal medications. R2's Med Admin Summary - Month dated March 2026 included miconazorbAF powder 2 percent (%) apply to affected areas as needed (PRN). The medication administration record (MAR) lacked specific resident instruction on where to apply the powder. R2's individual medication management plan comprised of multiple documents lacked specific resident instructions related to medication administration. On March 9, 2026, at approximately 9:50 a.m., during the entrance conference, clinical nurse supervisor (CNS)-C stated ULP administered PRN medications that were listed on the MAR. CNS-C stated the PRN medications would list indications for use and then the ULP would need to contact them within 24 hours of administering the PRN medication. On March 10, 2026, at 9:53 a.m., CNS-C stated R2 came to the licensee with the order listed above. CNS-C verified there were no instructions on where to apply the powder. CNS-C stated R2 used the powder on their legs and thighs however, they were attempting to get the order discontinued due to non-use. The licensee's undated Medication Management Policy and Procedure indicated the licensee must	01730		

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01730	Continued From page 33 develop and maintain a current individualized medication management record for each resident based on the resident assessment that must include documentation of specific resident instructions relating to the administration of medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01810 SS=F	144G.71 Subd. 12 Medications; over-the-counter drugs; dietary An assisted living facility providing medication management services for over-the-counter drugs or dietary supplements must retain those items in the original labeled container with directions for use prior to setting up for immediate or later administration. The facility must verify that the medications are up to date and stored as appropriate. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to secure over the counter (OTC) medication from three of three residents (R1, R2, R3). 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	01810		

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01810	Continued From page 34 a large portion or all of the residents). The findings include: R1 R1 was admitted to the licensee on January 23, 2026, and began receiving assisted living services on January 27, 2026. R1's diagnoses included altered mental status, and encephalopathy. R2 R2 was admitted to the licensee on January 7, 2026, and began receiving assisted living services. R2's diagnosis included traumatic brain injury. R5 R5 was admitted to the licensee on January 23, 2026, and began receiving assisted living services. R5's diagnosis included intracerebral hemorrhage (stroke). R1, R2, and R5's Individualized Medication Management Plan dated February 9, 2026, December 19, 2025, and February 11, 2026, respectively, indicated R1, R2 and R5's medications were stored in a locked medication cabinet. On March 10, 2026, at approximately 10:20 a.m., during a facility tour, the surveyor observed 11 packets of extra strength Tylenol 500 milligrams (mg) and one packet of Advil 200 mg located in a first aid kit located on the upper floor of the facility, unsecured in the hallway. Vice president	01810		

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01810	Continued From page 35 (VP)-E stated the first aid kit was left out in the event employees needed to use the kit for anything. VP-E removed the medication from the first aid kit to secure the medication. On March 11, 2026, at 3:01 p.m., clinical nurse supervisor (CNS)-C stated all medication should be locked and stored in a central location and narcotics should be double locked. CNS-C stated they typically avoided over the counter (OTC) medication, however, OTC medication still needed to be stored secured. CNS-C stated all medications needed to be secured. CNS-C stated they were not a part of making the first aid kits for the facility however, they were aware that any medication should be secured within the facility. The licensee's undated Medication Management Policy and Procedure indicated OTC medications that were not prescribed must retain the medication in the original labeled container with directions for use prior to setting up for immediate or later administration and the licensee must verify that the medications were up to date and stored as appropriate. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01810		

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

Evergreen Assisted Living Home
7016 Antrim Road
Edina, MN 55439
Hennepin County
Parcel:

Phone:

License Info

License: HFID 40475

Risk:
License:
Expires on:
CFPM: Sunny Sik Kim
CFPM #: 54295; Exp: 11/24/2027

Inspection Info

Report Number: F8041261044
Inspection Type: Full - Single
Date: 3/10/2026 Time: 11:00 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 1
Total Priority 3 Orders: 1
Delivery: Emailed

New Order: 2-300 Personal Cleanliness

2-301.15 *Priority Level: Priority 2 CFP#: 8*

MN Rule 4626.0080 Employees must wash their hands in a handwashing sink. Discontinue using the following sinks for handwashing: sinks used for food preparation or warewashing or a service sink or a curbed cleaning basin used for the disposal of mop water.

COMMENT: OBSERVED EMPLOYEE WASHING HANDS AT THE TWO BASIN SINK IN KITCHEN. USE SEPARATE HAND SINK IN KITCHEN THAT IS DESIGNATED FOR HANDWASHING. CORRECTED ON SITE.

Comply By: 3/10/2026 Originally Issued On: 3/10/2026

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: COOKED CHICKEN, RICE AND VEGGIES PREPARED YESTERDAY AND SAVED TO BE SERVED FOR DINNER SERVICE THE FOLLOWING DAY. SOME OF THE EQUIPMENT IN THE KITCHEN IS RESIDENTIAL AND FOOD MUST BE PREPARED FOR SAME DAY SERVICE ONLY. CORRECTED ON SITE. FOOD VOLUNTARILY DISCARDED BY PIC.

Comply By: 3/10/2026 Originally Issued On: 3/10/2026

Food & Beverage General Comment

Inspection was completed with the dietary manager, Wanda Hampton. Ashley Crews was the lead Health Regulation Division Nurse Evaluator.

This establishment has a residential kitchen with some commercial equipment. Food must be prepared for same day service only. The kitchen has wood cabinets with a hollow base, solid surface countertop, smooth ceiling and tile flooring.

Facility has two dish machine in the kitchen that were tested and achieved a utensil surface temperature of at least 160F for sanitizing. Commercial dishwasher in room was not in use and was not tested. Kitchen has a two basin sink and a separate handwashing sink. Garage has dry food storage, refrigerators and chest freezers.

Discussed the following:

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

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Metro District Office inspection report number F8041261044 from 3/10/2026

Wanda Hampton
Dietary Manager

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

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

Temperature Observations/Recordings

Establishment Info

Evergreen Assisted Living Home
Edina
County/Group: Hennepin County

Inspection Info

Report Number: F8041261044
Inspection Type: Full
Date: 3/10/2026
Time: 11:00 AM

Food Temperature: Product/Item/Unit: pepperoni**; Temperature Process:** Cold-Holding
Location: sliding door cooler/garage at 40 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: sour cream**; Temperature Process:** Cold-Holding
Location: kitchen cooler at 33 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: chicken**; Temperature Process:** Cold-Holding
Location: kitchen cooler 2 at 41 Degrees F.
Comment:
Violation Issued?: No

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL40475015-0	**Date:** 3/12/2026
Facility Name: Evergreen/Eagles Nest Assisted Living	
Facility Address: 7016 Antrim road Edina MN 55439	

☒ **TAG IDENTIFICATION: 0810**

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

1. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include employee actions to be taken in the event of a fire or similar emergency. [Minn. Stat. 144G.45 subd.2]

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

2. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include fire protection procedures necessary for residents. [Minn. Stat. 144G.45 subd.2]

   Comments: Licensed assisted living director (LALD)-D stated there was no resident policy created at this time.