Electronically Delivered

October 8, 2025

Licensee
Legacy Care Home
5531 Eden Prairie Road
Minnetonka, MN 55345

RE: Project Number(s) SL33588016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 26, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH 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. MDH documents state licensing 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 . . ."

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
In accordance with 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 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

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,

Renee L. Anderson

Renee L. Anderson, Supervisor
State Evaluation Team
Email: Renee.L.Anderson@state.mn.us
Telephone: 651-201-5871 Fax: 1-866-890-9290

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33588	A. BUILDING: _____ B. WING _____	08/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY CARE HOME	5531 EDEN PRAIRIE ROAD MINNETONKA, MN 55345

(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 In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: SL33588016-0 On August 25, 2025, through August 26, 2025, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were eight (8) residents, all of whom were receiving services under the provider's Assisted Living with Dementia Care 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 with Dementia Care. 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.	
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control	0 660		

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0 660	Continued From page 1 (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), to include an updated facility TB risk assessment. 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 the potential to affect a large portion or all of the residents).	0 660		

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0 660	Continued From page 2 The findings include: The licensee's Facility TB Risk Assessment dated April 2022, was completed on January 4, 2025. The assessment identified the national rate was 2.9 percent/per 100,000 population in year 2023, and the Minnesota rate was 2.8 percent/per 100,000 population in year 2023. The assessment form and data used to complete the incidence of TB was not current information at the time the assessment was completed. Also, the assessment was blank under the following areas of the assessment: TB screening of health care personnel; infection control plan; TB training plan; and quality improvement. On August 26, 2025, at 3:10 p.m., licensed assisted living director (LALD)-A stated she was the one who completed the Facility TB Risk Assessment on January 4, 2025; however, did not realized that she had been using the data from 2023 instead of data from 2024. In addition, LALD-A stated she would look into it, and complete the facility TB risk assessment with the most current data. On August 4, 2025, at 11:47 a.m., clinical nurse supervisor (CNS)-D stated they were not very familiar with the Facility TB Risk Assessment. Agent (A)-C stated the Facility TB Risk Assessment had been completed a little over a year ago prior to CNS-D's employment with the licensee. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include a	0 660		

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0 660	Continued From page 3 facility TB risk assessment. The guidelines also indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record." The licensee's Infection Control policy dated August 1, 2021, indicated licensee's infection control program would be consistent with current guidelines from CDC for prevention control in long-term care facilities, and where applicable in assisted living facilities. In addition, licensee would identify areas where infection control practices were necessary based on the exposure and risk of the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment	01440		

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01440	Continued From page 4 administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. 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 supervision of unlicensed staff as required for one of two unlicensed personnel, (ULP)-D. 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-D was hired on July 4, 2025, and provided direct care and services to residents, under the facility's assisted living with dementia care license.	01440		

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01440	Continued From page 5 ULP-D's employee record lacked evidence an RN conducted direct supervision of ULP-D within 30-days of performing delegated tasks. On August 26, 2025, at 2:55 p.m., licensed assisted living director (LALD)-A stated ULP-D was supervised by her, in January 2025, administering medications at another one of licensee's sister facilities. LALD-A further stated ULP-D had been administering medications at the current facility; however, his employee record lacked 30-day supervision of medication administration at the current facility. Moreover, LALD-A stated she was unaware 30-day supervision was a requirement for each sister facility a ULP worked in; therefore 30-day supervision was not conducted. The licensee's Supervision of Staff-Delegated Services policy dated August 1, 2021, indicated staff who provided delegated nursing or therapy tasks to residents would be supervised by an RN or appropriate licensed health professional where the services are being provided. Furthermore, direct supervision of staff performing delegated tasks would be provided within 30 calendar days after the date on which the individual began working for licensee and first performed the delegated tasks for residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01450 SS=D	144G.62 Subd. 5 Documentation A facility must retain documentation of	01450		

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01450	Continued From page 6 supervision activities in the personnel records. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure documentation of direct supervision of staff performing delegated tasks was retained in the employee's record for one of two unlicensed personnel (ULP-D). 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-D was hired on July 4, 2025, and provided direct care and services to residents, under the facility's assisted living with dementia care license. ULP-D's employee training record lacked evidence of documentation of a registered nurse (RN) supervising ULP-D performing delegated tasks in accordance with assisted living statutes beginning August 1, 2021. On August 26, 2025, at 2:55 p.m., licensed assisted living director (LALD)-A stated she was unaware 30-day supervision was a requirement for each sister facility a ULP worked in; therefore 30-day supervision was not conducted at licensee's current facility; therefore, ULP-D's	01450		

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01450	Continued From page 7 would not have documentation that 30-day supervision was completed. The licensee's Supervision of Staff-Delegated Services policy dated August 1, 2021, indicated staff who provided delegated nursing or therapy tasks to residents would be supervised by an RN or appropriate licensed health professional where the services are being provided. Furthermore, direct supervision of staff performing delegated tasks would be provided within 30 calendar days after the date on which the individual began working for licensee and first performed the delegated tasks for residents. Moreover, documentation of supervision activities would be retained in the employee's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01450		
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their	02170		

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02170	Continued From page 8 activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to conduct an evaluation for activities that addressed all provisions and failed to develop an individualized activity plan based on the evaluation, for two of two residents (R4, R5) who resided in the secured memory care unit. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all	02170		

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02170	Continued From page 9 of the residents). The findings include: The facility had an assisted living with dementia care license, effective August 1, 2021. R4 R4 was admitted to licensee's assisted living with dementia care facility on July 1, 2025. R4's diagnoses included, but were not limited to, dementia (memory disorder), insomnia, visual disturbances, and hypertension. R4's Uniform Assessment Tool dated July 1, 2025, page 4, titled "Leisure Activities" evaluation included current interests; however, lacked required documentation of the following: - current limitations; - current abilities and skills; - emotional and social needs and patterns; - physical abilities; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions. In addition, R4's activity service or care plan lacked a selection of daily structured and non-structured activities as appropriate. R5 R5 was admitted to licensee's assisted living with dementia care facility on September 5, 2024. R5's diagnoses included, but were not limited to, dementia (memory disorder), Wernicke Korsakoff syndrome (memory disorder), schizoaffective disorder (mental health condition), epilepsy, and hypertension.	02170		

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02170	Continued From page 10 R5's Uniform Assessment Tool dated September 5, 2024, page 4, titled "Leisure Activities" evaluation included current interests; however, lacked required documentation of the following: - current limitations; - current abilities and skills; - emotional and social needs and patterns; - physical abilities; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions. In addition, R4's activity service or care plan lacked a selection of daily structured and non-structured activities as appropriate. On August 26, 2025, at 2:12 p.m., licensed assisted living director (LALD)-A stated R4 and R5's Uniform Assessment tool lacked all the required content noted above. LALD-A further stated licensee utilized the Uniform Assessment Tool for all residents of the facility to evaluate their lifestyle and leisure interests, and thought all required areas had been addressed. In Addition, LALD-A stated she was unaware of the requirement to develop an individualized activity plan; however, it did make sense. Licensee's posted Activity Calendar dated August 2025, indicated one activity per day August 1, 2025, through August 31, 2025, which had not been developed based on resident's individual needs and preferences. Licensee's Assisted Living with Dementia Care (ALFDC) Life Enrichment Programs, Activities, and Outdoor Space policy dated August 1, 2021, indicated licensee would strive to provide valuable activities and life enrichment programs	02170		

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02170	Continued From page 11 for residents with Alzheimer's disease or other dementias. Furthermore, each resident would be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation would address the following: - past and current interests; - current limitations; - current abilities and skills; - emotional and social needs and patterns; - physical abilities; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions. In addition, licensee would develop an individualized activity plan for each resident based on their activity evaluation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02170		

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

LEGACY CARE HOME
5531 EDEN PRAIRIE ROAD
Minnetonka, MN 55345
Hennepin County
Parcel:

Phone:

License Info

License: HFID 33588

Risk:
License:
Expires on:
CFPM: Robyn Tamme
CFPM #: 120785; Exp: 1/18/2027

Inspection Info

Report Number: F8041251111
Inspection Type: Full - Single
Date: 8/26/2025 Time: 10:00 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: In Person

No orders were issued for this inspection report.

Food & Beverage General Comment

Inspection was completed with Robyn Tamme and Cat Hemp. Rhonda Makela was the lead Health Regulation Division Nurse Evaluator. Facility had 8 residents at time of inspection.

The kitchen has cabinets on stainless 6 inch legs with a solid surface countertop, tile flooring, a separate sink for handwashing and commercial refrigeration.

Establishment has an NSF residential Bosch dishwasher that achieved a temp at least 160F for sanitizing dishes.

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 F8041251111 from 8/26/2025

Cat Hemp
Director of Nursing

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

LEGACY CARE HOME
Minnetonka
County/Group: Hennepin County

Inspection Info

Report Number: F8041251111
Inspection Type: Full
Date: 8/26/2025
Time: 10:00 AM

Food Temperature: Product/Item/Unit: milk**; Temperature Process:** Cold-Holding
Location: arctic air cooler at 40 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: meatball**; Temperature Process:** Cold-Holding
Location: arctic air cooler at 39 Degrees F.
Comment:
Violation Issued?: No