Electronically Delivered

October 16, 2025

Licensee
Saint Therese of Corcoran LLC
19810 79th Place
Corcoran, MN 55340

RE: Project Number(s) SL39901015

Dear Licensee:

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

The Minnesota Department of Health completed an initial survey on September 4, 2025, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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

STATE CORRECTION ORDERS

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

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.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00

The total amount you are assessed is $500.00. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under

this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by MDH within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39901	A. BUILDING: _____ B. WING _____	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT THERESE OF CORCORAN LLC	19810 79TH PLACE CORCORAN, MN 55340

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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: SL39901015-0 On September 2, 2025, through September 4, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 11 residents receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 650 SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of	0 650		

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0 650	Continued From page 1 each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records included all required content for one of two employees (unlicensed personnel (ULP)-B). 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).	0 650		

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0 650	Continued From page 2 The findings include: On September 3, 2025, at 8:00 a.m., the surveyor observed ULP-B assist R3 with medication administration. ULP-B was hired on October 24, 2024, to provide direct care to residents. ULP-B's personnel record lacked: - documentation of supervision by the RN within 30 days of performing delegated tasks; and - baseline tuberculosis (TB) screening that included assessment for current symptoms of active TB disease and TB history. 30-DAY SUPERVISION On September 3, 2025, at 10:28 a.m., clinical nurse supervsior (CNS)-A stated they do supervise and observe the ULPs performing tasks as they usually do this initially, day three and again on day six. CNS-A stated they were not aware of a form the licensee used to document the supervision. TB On September 3, 2025, at 10:19 a.m., human resource manager (HRM)-F stated they did not onboard ULP-B and would check with the corporate office for the TB screening. On September 3, 2025, at 10:43 a.m., HRM-F stated they always have the employees fill out the TB screening; and they did not know why they could not find the TB screening in ULP-B's record. On September 3, 2025, at 11:05 a.m., HRM-F stated ULP-B was hired and trained by corporate.	0 650		

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0 650	Continued From page 3 HRM-F stated they called the clinic, but the clinic would not release the symptom and history screening without a consent. HRM-F stated they were not sure why it was not in the personnel record. The licensee's Personnel Records policy dated October 31, 2022, indicated the personnel records would include all required training and competency evaluations, results of supervision observations, and TB screening results. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with Minnesota State Fire Code in Minnesota Rules chapter 7511. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a 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	0 775		

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0 775	Continued From page 4 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 2, 2025, at approximately 1:00 p.m., the surveyor toured the facility with director of maintenance (DM)-E, executive director of project management (EDPM)-C, and licensed assisted living director (LALD)-D. The following was observed. 1. The 1st floor laundry room fire rated door did not latch and seal. Swinging fire doors shall close from the full-open position and latch automatically. 2. The chapel doors are rated fire doors with tags on the hinge side of the door, smoke seal, and closers. The doors are also equipped wall mounted door hold open devices permanently attached to the doors. Fire doors and smoke and draft control doors shall not be blocked, obstructed, or otherwise made inoperable. On September 2, 2025, EDPM-C, LALD-D, and DM-E acknowledged the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping	0 810		

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

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0 810	Continued From page 6 safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 2, 2025, director of maintenance (DM)-E, executive director of project management (EDPM)-C, and licensed assisted living director (LALD)-D provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP failed to include the following: The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. LALD-D stated a procedure was not in place. On September 2, 2025, LALD-D stated they understood the area of their policy that was missing and would work to create a policy. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		

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01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (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 the required content for two of two residents (R2, R3). This practice resulted in a level two violation (a	01650		

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01650	Continued From page 8 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: R2's diagnoses including type 2 diabetes. R3's diagnoses including congestive heart failure (CHF). R2 and R3's Service Plans dated April 29, 2025, and July 14, 2025, respectively, lacked the following content: -frequency of each service, according to the resident's current assessment and resident preferences. On September 3, 2025, at 2:30 p.m., clinical nurse supervisor (CNS)-A stated R2 and R3's service plans were missing the frequency of each service. CNS-A stated they were aware of the required content of the service plan. However, there is glitch in the system currently being used and it is missing some of the service frequencies. CNS-A stated they were working on fixing the issue, but for now this was the service plan used for all residents. The licensee's Contents of Service Plans policy dated October 2022, indicated a service plan would include: a. A description of the services that are to be provided based on the most recent assessment and resident preferences	01650		

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01650	Continued From page 9 b. Fees for services to be provided c. The frequency of each service to be provided based on the most recent assessment and resident preferences d. An identification of staff or categories of staff who will be providing services (RN, LPN, unlicensed personnel, etc.) e. A schedule and method for the next planned assessment or monitoring f. A schedule and method for the next planned monitoring of staff providing services g. A contingency plan that includes: i. Actions [licensee] will take if scheduled services cannot be provided ii. Information regarding how the resident can contact [licensee] iii. The names and contact information the resident wishes, if any, to have notified in an emergency or if there is a significant adverse change in the resident's condition iv. Identification and contact information of who the resident has authorized, if any, to sign for the resident in an emergency v. How the facility will support documented resident health care directive decisions, if any - including circumstances when emergency medical services are not to be summoned. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription	01890		

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01890	Continued From page 10 label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription label with legible information including the expiration date for time sensitive medications for two 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 a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On September 2, 2025, at 11:55 a.m., during initial tour with executive director project management (EDPM)-C, unlicensed personnel (ULP)-B) unlocked the medication cart and the surveyors observed the following: - R2's prescribed Humalog (short-acting insulin used to treat diabetes) pre-filled pen lacked the dates the pens had been opened and the dates the pens would expire. - unidentified resident prescribed Lantus (long-acting insulin used to treat diabetes) pen missing information regarding the directions for use, medication name, medication dosage, and resident's name.	01890		

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01890	Continued From page 11 On September 2, 2025, at 12:00 p.m., ULP-B stated "I usually write the open date on the insulin pen, they are good for one month or 28 days. I am not sure about the Lantus pen as I don't give them, and it is only given nighttime". On September 3, 2025, at 3:00 p.m., clinical nurse supervisor (CNS)-A stated the medication labeling process was for the insulin pens to have the date filled out by staff when first taken out of the medication refrigerator for use. Also, CNS-A acknowledged the Lantus pen was missing information regarding the directions for use, medication name, medication dosage, and resident's name and CNS-A stated "we are using up her insulin pen that she brought from home. The pharmacy won't send any labels." The manufacturer's instructions for Lantus dated August 2022, directed to discard the pen 28 days after opening, even if it had insulin in it. The manufacturer's instructions for Humalog revised dated July 2023, directed to discard the pen 28 days after opening, even if it had insulin in it. The licensee's Storage of Medications policy dated October 2022, indicated the registered nurse (RN) would provide education to the resident/resident's representative on proper storage of medications in the home including the need to be refrigerated, or stored in a cool, dry area, and according to manufacturer's recommendations. This may include a combination of the resident's room and the nursing office. No further information was provided.	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39901	A. BUILDING: _____ B. WING _____	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT THERESE OF CORCORAN LLC	19810 79TH PLACE CORCORAN, MN 55340

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01890	Continued From page 12 TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for one of one resident (R1) with bed rails. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 3, 2025, at 8:00 a.m., the surveyor observed R3's bed was a hospital style bed with bilateral upper bed rails. The bed rails were grabbed by unlicensed personnel (ULP)-B and the bed rails were secured and not loose.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39901	A. BUILDING: _____ B. WING _____	09/04/2025

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02310	Continued From page 13 R3's Service Plan dated July 15, 2025, indicated R3 received assisted living services that included medication administration and assistance with activities of daily living (ADLs). R3's Physical Device Evaluation dated July 29, 2025, indicated R3 had half side rail(s) used for positioning/mobility. The bed rail assessment indicated the side rails passed the Food and Drug Administration (FDA) zones of entrapment one through four. The bed rail assessment lacked documentation of specific measurements of zones of entrapment. On September 3, 2025, at 11:22 a.m., clinical nurse supervisor (CNS)-A stated they measured the bed rails to make sure they were compliant but did not document the actual measurements. The licensee's Proper Use of Side Rails policy dated April 1, 2022, indicated the licensee would assure the correct installation and maintenance of bed rails included checking with the manufacturer(s) to make sure the bed rails, mattress, and bed frame were compatible. The policy indicated the licensee would assess the resident for risks of entrapment, and other risks associated with the use of side/bed rails. The FDA's Guidance for Industry and FDA Staff: Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, revised March 10, 2006, on page 21, Table 3 Summary of FDA Hospital Bed Dimensional Limit Recommendations indicated specific measurement limits for each entrapment zone. Also, on page 27, Appendix E, indicated drawings of potential entrapment in hospital beds. According to The Minnesota Department of	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39901	A. BUILDING: _____ B. WING _____	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02310	Continued From page 14 Health's (MDH) Assisted Living: Resources and Frequently Asked Questions (FAQs) website accessed on September 10, 2025, at 2:59 p.m., indicated under Hospital-style bed rails, the licensee must ensure the bed rail measurements were documented. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	02310		

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

SAINT THERESE OF CORCORAN LLC
19810 79TH PLACE
Corcoran, MN 55340
Hennepin County
Parcel:

Phone:

License Info

License: HFID 39901

Risk:
License:
Expires on:
CFPM:
CFPM #: ; Exp:

Inspection Info

Report Number: F8087251100
Inspection Type: Full - Single
Date: 9/2/2025 Time: 4:00:00 PM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

FACILITY IS NEW AS OF 2024.

KITCHEN IS LOCATED IN THE INDEPENDENT LIVING SECTION OF THE BUILDING WHICH IS UNLICENSED. KITCHEN IS SEPARATELY LICENSED BY THE HENNEPIN COUNTY HEALTH DEPARTMENT AND IS INSPECTED ANNUALLY BY THIS AGENCY.

ASSISTED LIVING SECTION OF THE BUILDING HAS A SMALL DINING ROOM WHICH IS SERVICED BY THE KITCHEN AND HAS 2 SMALL SNACK AREAS THAT HAVE PREPACKAGED DRY GOODS AVAILABLE.

ESTABLISHMENT ALSO HAS A POOL THAT IS LICENSED AND INSPECTED BY THE HENNEPIN COUNTY HEALTH DEPARTMENT.

REPORT EMAILED TO FACILITY AND NURSE SURVEYOR.

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 F8087251100 from 9/2/2025

John Boettcher

KATELYN HUDSON
EXECUTIVE DIRECTOR

John Boettcher,
Public Health Sanitarian 3
651-201-5076
john.boettcher@state.mn.us