Electronically Delivered

August 7, 2025

Licensee
Arden Homes LLC
6436 June Avenue North
Brooklyn Center, MN 55429

RE: Project Number(s) SL38872016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 11, 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.

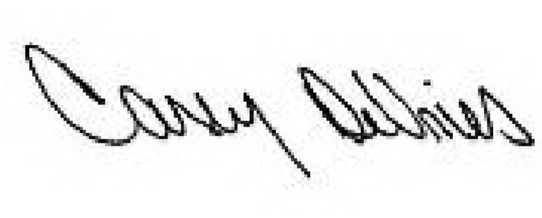
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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,



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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38872	A. BUILDING: _____ B. WING _____	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARDEN HOMES LLC	6436 JUNE AVENUE NORTH BROOKLYN CENTER, MN 55429

(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: SL38872016-0 On June 9, 2025, through June 11, 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 three residents all of whom received 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.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated June 10, 2025, 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		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to 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.	0 680		

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0 680	Continued From page 4 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 June 10, 2025, at 11:00 a.m., the surveyor reviewed the licensee's EPP dated January 7, 2025. The EPP lacked the following required content: - program patient population; - subsistence needs for staff and patients; - sharing information on occupancy/needs; and - LTC family notifications. On June 10, 2025, at 2:35 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated they had been working on their EPP with the help of a consultant and that they were not done yet. The licensee's Emergency Preparedness Plan - Appendix Z Compliance policy dated August 1, 2021, indicated the licensee would have in place an effective and compliant Emergency Preparedness Plan, and the intent was the plan would be aligned with the Centers for Medicare and Medicaid Services State Operation Manual Appendix Z: "State Operations Manual Appendix Z - Emergency Preparedness for All Provides and Certified Supplier Types: Interpretive Guidance." No further information was provided.	0 680		

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0 680	Continued From page 5 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 790 SS=F	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. This deficient condition had the potential to affect all staff, residents, 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On June 11, 2025, from 9:30 a.m. to 11:00 a.m.,	0 790		

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0 790	Continued From page 6 the surveyor toured the facility with clinical nurse supervisor/ licensed assisted living director (CNS/LALD)-A. The portable fire extinguishers throughout the facility lacked records to show the required annual certification was completed. The portable fire extinguishers throughout the facility lacked records to show monthly visual inspections were complete. Documentation is required to demonstrate fire extinguishers have been inspected by facility personnel monthly, and annually replaced with a new extinguisher or serviced annually by a certified technician. On June 11, 2025, CNS/LALD-A stated they signed a contract in May 2025, with a third-party certified technician to do the annual certification, but they had not completed the inspection by the date of the survey. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.	0 800		

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0 800	Continued From page 7 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, in a continuous state of good repair and operation. This deficient condition had the potential to affect all staff, residents, 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: On June 11, 2025, from 9:30 a.m. to 11:00 a.m., the surveyor toured the facility with clinical nurse supervisor/ licensed assisted living director (CNS/LALD)-A. The surveyor observed the following: The exterior wall adjacent to the garage had significant damage to the exterior stucco. The stucco material was cracked in multiple locations and bulging out from the structure. The same exterior wall had a large whole in the window head trim under the garage roof soffit. The roof to wall transitions on the front and back slope of the garage roof from the garage roof to the adjacent wall were deteriorated with holes and gaps along the entire joint. The interior walls and door frames on the main	0 800		

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0 800	Continued From page 8 level had significant damage from the floor to approximately 36 inches above the floor. CNS/LALD-A stated the damage was caused by the use of motorized wheel chairs inside the house. The main level bathroom wall was damaged adjacent to the shower. A large piece of tile was missing, exposing the building structure behind. The wall structure behind the tile had water damage and dark staining. These deficient conditions were visually verified by CNS/LALD-A accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
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	0 810		

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0 810	Continued From page 9 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, to provide the required training, and to conduct evacuation drills. 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 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 June 11, 2025, clinical nurse supervisor/ licensed assisted living director (CNS/LALD)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and	0 810		

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0 810	Continued From page 10 evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, 1.05 Handling of Emergencies and use of Emergency Services - Fire Emergency, dated August 1, 2021, failed to include the following: The FSEP failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine and Extinguish or Evacuate) but failed to include procedures for how staff are to complete each step. The FSEP did not identify specific fire protection actions for residents. The section of the FSEP for residents, Procedures for residents in the event of a fire or similar emergency, indicated residents should wait for guidance and direction from the staff during a fire evacuation. The policy lacked instructions to residents on how to safely evacuate the building in an emergency. On June 11, 2025, at 12:30 p.m., CNS/LALD-A stated they didn't understand that the third-party policy they were using was not correct. CNS/LALD-A stated they would work on bringing them into compliance. The policy reviewed was an unedited policy from a third-party provider that was not specific to the facility. TRAINING: The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. The licensee's training records, Staff Fire Safety and Evacuation Training,	0 810		

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0 810	Continued From page 11 undated, indicated staff were trained upon hire and once per year thereafter. No other training documentation was provided. On June 11, 2025, at 12:30 p.m., CNS/LALD-A stated they could not find the training records for employees. The surveyor requested training records be emailed by 3:00 p.m. on June 11, 2025. Email received at 1:06 p.m. on June 11, 2025, from CNS/LALD-A included training records for three employees. All training records in the received documents were dated in May and June of 2025. No records provided for 2024 or 2023. DRILLS: The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Record review of licensee's evacuation drill log, Fire Drill Report, undated, indicated evacuation drills were conducted on January 9, 2025, March 10, 2025, and May 2, 2025. No other documentation was provided. On June 11, 2025, at 12:30 p.m., CNS/LALD-A stated they could not find the evacuation drill records prior to January 2025. The surveyor requested additional evacuation drill records be emailed by 3:00 p.m. on June 11, 2025. Email received at 1:06 p.m. on June 11, 2025, from CNS/LALD-A stated they could not locate the drill records from 2024. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility	0 970		

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ARDEN HOMES LLC	6436 JUNE AVENUE NORTH BROOKLYN CENTER, MN 55429

(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
0 970	Continued From page 12 liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. 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 include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's blank Resident Agreement Assisted Living included the following section which contained language waiving the licensee's liability for health, safety, or personal property of a resident: "INDEMNIFICATION: Resident will indemnify and hold harmless provider, its employees and agents from and against any and all claims, actions, damages, and liability and expense in connection with loss of	0 970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38872	A. BUILDING: _____ B. WING _____	06/11/2025

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0 970	Continued From page 13 life, personal injury or damage to property, arising from or out of the use by resident of the rented premises or any other part of provider's property, or caused wholly or in part by an act or omission of resident or resident's guests or agents." On June 10, 2025, at 2:30 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated they had updated their contract after their previous survey and that the same contract was used for the licensee's residents. CNS/LALD-A also stated they were not aware they had another waiver language in their contract. The licensee's Signing an Assisted Living Contract policy dated August 1, 2021, indicated a prospective resident will sign an assisted living contract at the time of move in. The contract did not have a verbiage to include waiving the facility's liability for health, safety, or personal property of a resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum:	01060		

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01060	Continued From page 14 (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, or designated	01060		

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01060	Continued From page 15 representative, and the Office of Ombudsman for Long-Term Care within four days for one of one resident (R3) with an emergency relocation. 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: R3 was admitted to the licensee and began receiving assisted living services on June 30, 2023. R3's Nursing Note dated May 20, 2025, indicated R3 was transported to Mercy Hospital via emergency medical services (EMS). R3's care team email dated May 21, 2025, indicated R3 was discharged from the hospital to a transitional care unit (TCU) for ongoing rehabilitative care. On June 10, 2025, at 2:45 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated they had not sent out the required emergency relocation notification. CNS/LALD-A also stated they were aware of the requirement, but it had slipped through. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		

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01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this	01500		

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01500	Continued From page 17 subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure employees received at least eight hours of annual training for each 12 months of employment for one of two employees licensed practical nurse (LPN)-C. 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 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: LPN-C started employment with the licensee on July 1, 2022, to provide assisted living services to residents.	01500		

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01500	Continued From page 18 LPN-C's Annual Training Tracking Form dated July 1, 2024, indicated LPN-C had completed training in the following topics: - an introduction and review of policies and procedures relevant to the provision of assisted living services; - review of infection control techniques and implementation of infection control standards; - handling of emergencies and use of emergency services; - Minnesota vulnerable adults act compliance with and reporting suspected maltreatment of vulnerable adults; - review of current Assisted Living Bill of rights; - clean and safe environment; - recognition of resident needs; - principles of person centered planning; and - effective approaches to use to problem solve when working with a resident's challenging behaviors. LPN-C's employee record did not indicate the number of hours for each training received. LPN-C's record also lacked the following required topic: - review of the facility's policies and procedures relating to the provision of assisted living services. On June 10, 2025, at 2:45 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated they were not aware they needed to include the number of hours for each training completed. The licensee's Staff Orientation and Education policy dated August 1, 2021, indicated all staff providing assisted living services will complete at least eight (8) hours of education for every twelve	01500		

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01500	Continued From page 19 (12) months of employment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01530 SS=F	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	01530		

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01530	Continued From page 20 issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct-care staff completed at least eight hours of initial dementia care training within 160 working hours of the employment start date for two of two employees (unlicensed personnel (ULP)-B, licensed practical nurse (LPN)-C). 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: ULP-B ULP-B began employment with the licensee on January 6, 2025, to perform direct care services to residents, and worked full time (FT) mornings. On June 10, 2025, at 8:35 a.m., the surveyor observed ULP-B assist R2 with medication	01530		

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01530	Continued From page 21 administration, and worked FT evenings. LPN-C LPN-C began employment with the licensee on July 1, 2022, to perform direct care services to residents. ULP-B and LPN-C's Dementia Training Tracking Forms dated January 12, 2025, and July 5, 2022, indicated ULP-B and LPN-C had received dementia training on the following topics: - an explanation of Alzheimer's disease and other dementias; - assistance with activities of daily living; - problem solving with challenging behaviors; - communication skills; - person centered planning and service delivery; - understanding cognitive impairment; and - standards of dementia care including nonpharmacological. ULP-B and LPN-C's record did not indicate the number of hours for each topic trained. On June 10, 2025, at 2:50 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated they were not aware they needed to track the number of hours for each topic trained. CNS/LALD-A also stated they trained their staff on all the required topics, but did not document the number of hours for each topic trained. The licensee's Dementia Training policy dated August 1, 2021, indicated all staff of [licensee] are required to complete dementia training at the time of hire and annually thereafter. The policy did not indicate the number of hours for each topic trained.	01530		

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01530	Continued From page 22 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		

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

Arden Homes LLC
6436 June Avenue North
Brooklyn Center, MN 55429
Hennepin County
Parcel:

Phone:

License Info

License: HFID 38872

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

Inspection Info

Report Number: F1005251037
Inspection Type: Full - Single
Date: 6/10/2025 Time: 10:45:06 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 2
Total Priority 2 Orders: 2
Total Priority 3 Orders: 1
Delivery: Emailed

! **New Order: 3-500B Microbial Control: hot and cold holding**
3-501.16A *Priority Level: Priority 1 CFP#: 22*
MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.
COMMENT: DELI MEAT IN THE REFRIGERATOR WAS 43 DEGREES F. UNIT WAS ADJUSTED TO A COLDER SETTING.
Comply By: 6/10/2025 Originally Issued On: 6/10/2025

New Order: 3-500C Microbial Control: date marking
3-501.17B *Priority Level: Priority 2 CFP#: 23*
MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.
COMMENT: OPENED DELI MEAT AND MILK WERE NOT DATE MARKED. MARK THE DATE THAT TCS FOODS ARE OPENED TO ENSURE THEY ARE USED OR DISCARDED WITHIN 7 DAYS. FACT SHEET EMAILED WITH REPORT.
Comply By: 6/10/2025 Originally Issued On: 6/10/2025

New Order: 4-200 Equipment Design and Construction
4-204.112A *Priority Level: Priority 3 CFP#: 36*
MN Rule 4626.0620A Provide a temperature measuring device located in the warmest part of mechanically refrigerated units and coolest part of hot food storage units that are capable of measuring air temperature or a simulated product temperature.
COMMENT: THE AMBIENT THERMOMETER IN THE REFRIGERATOR WAS READING 30 DEGREES F, BUT FOODS WERE ACTUALLY 41-43 DEGREES F. REPLACE THERMOMETER.
Comply By: 6/17/2025 Originally Issued On: 6/10/2025

New Order: 4-300 Equipment Numbers and Capacities
4-301.12A *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0680A Provide a 3 compartment sink with integrally attached drainboards at each end for manually washing, rinsing and sanitizing equipment and utensils.
COMMENT: THE DISHWASHER ON SITE IS NOT OPERATIONAL. FACILITY MUST PROVIDE EITHER A 3 COMPARTMENT SINK WITH DRAINBOARDS OR A DISHWASHER LARGE ENOUGH TO ACCOMMODATE ALL EQUIPMENT.

6/13/25 VIDEO WAS SENT TO INSPECTOR SHOWING THAT THE DISHWASHER IS NOW WORKING.
Comply By: 6/17/2025 Originally Issued On: 6/10/2025

! **New Order: 4-700 Sanitizing Equipment and Utensils**
4-702.11 *Priority Level: Priority 1 CFP#: 16*
MN Rule 4626.0900 Sanitize utensils and food contact surfaces of equipment before use, after cleaning.
COMMENT: THE COUNTERTOP DISHWASHER ON SITE WAS NOT HOOKED UP FOR USE, AND STAFF COULD NOT LOCATE THE HOSES NEEDED TO OPERATE IT. DISCUSSED THE STEPS FOR TEMPORARILY WASHING, RINSING, AND SANITIZING DISHES IN THE TWO COMPARTMENT KITCHEN SINK UNTIL DISHWASHER IS FUNCTIONING.

6/13/25 VIDEO WAS SENT TO INSPECTOR SHOWING THE DISHWASHER HOOKED UP AND OPERATIONAL, AND ACHIEVING A UTENSIL SURFACE TEMPERATURE OVER 160 DEGREES F.
Comply By: 6/10/2025 Originally Issued On: 6/10/2025

Food & Beverage General Comment

INSPECTION COMPLETED WITH STAFF AND REVIEWED WITH HRD NURSING EVALUATOR BENARD NYANGENA.

DISCUSSED ORDERS ON REPORT AS WELL AS GLOVE USE, COOKING TEMPERATURES, CROSS-CONTAMINATION, AND EMPLOYEE ILLNESS.

DISCUSSED THAT DISHES NEED TO BE WASHED, RINSED, AND SANITIZED IN THE 2-COMPARTMENT KITCHEN SINK UNTIL DISHWASHER IS REPAIRED. A CHLORINE (BLEACH) SOLUTION OF 50-100 PPM CAN BE USED TO SANITIZE.

THREE DAYS AFTER INITIAL INSPECTION, ON 6/13/25, VIDEOS WERE SENT TO INSPECTOR SHOWING THAT THE DISHWASHER IS NOW WORKING AND PROVIDED A UTENSIL SURFACE TEMPERATURE OF 208 DEGREES F, SO ALL DISHES CAN NOW BE CLEANED AND SANITIZED IN THE DISHWASHER.

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

FLOORING IS LAMINATE AND CABINETS ARE WOOD WITH HOLLOW BASE. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

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 F1005251037 from 6/10/2025

JOSLYN DAYRELL
DIRECTOR OF NURSING, LALD

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

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

Temperature Observations/Recordings

Establishment Info

Arden Homes LLC
Brooklyn Center
County/Group: Hennepin County

Inspection Info

Report Number: F1005251037
Inspection Type: Full
Date: 6/10/2025
Time: 10:45:06 AM

Food Temperature: Product/Item/Unit: DELI TURKEY MEAT**; Temperature Process:** Cold-Holding
Location: KITCHEN REFRIGERATOR at 43 Degrees F.
Comment:
Violation Issued?: Yes

Food Temperature: Product/Item/Unit: MILK**; Temperature Process:** Cold-Holding
Location: KITCHEN REFRIGERATOR at 41 Degrees F.
Comment:
Violation Issued?: No