Electronically Delivered

October 22, 2025

Licensee
Holistic Health Care Services LLC
1544 Roundhouse Circle
Shakopee, MN 55379

RE: Project Number(s) SL38114016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 18, 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.

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 . . ."

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 - $1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

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 the Department of Health 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.

INFORMAL CONFERENCE

In accordance with Minn. Stat. § 144A.475, Subd. 8 OR Minn. Stat. § 144G.20, Subd. 20, the Commissioner of Health is authorized to hold a conference to exchange information, clarify issues, or resolve issues. The Department of Health staff would like to schedule a conference call with Holistic Health Care Services. **Please contact Jodi Johnson at 507-344-2730 on or before October 25, 2025, to schedule the conference call.**

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

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

If you have any questions, please contact me.

Sincerely,

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

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38114	A. BUILDING: _____ B. WING _____	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLISTIC HEALTH CARE SERVICES LLC	1544 ROUNDHOUSE CIRCLE SHAKOPEE, MN 55379

(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: SL38114016-0 On September 15, 2025, through September 18, 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 was one resident; one 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.	
0 100 SS=F	144G.10 Subdivision 1 License required	0 100		

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0 100	Continued From page 1 (a)(1) Beginning August 1, 2021, no assisted living facility may operate in Minnesota unless it is licensed under this chapter. (2) No facility or building on a campus may provide assisted living services until obtaining the required license under paragraphs (c) to (e). (b) The licensee is legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. Nothing in this chapter shall in any way affect the rights and remedies available under other law. (c) Upon approving an application for an assisted living facility license, the commissioner shall issue a single license for each building that is operated by the licensee as an assisted living facility and is located at a separate address, except as provided under paragraph (d) or (e). If a portion of a licensed assisted living facility building is utilized by an unlicensed entity or an entity with a license type not granted under this chapter, the licensed assisted living facility must ensure there is at least a vertical two-hour fire barrier as defined by the National Fire Protection Association Standard 101, Life Safety Code, between any licensed assisted living facility areas and unlicensed entity areas of the building and between the licensed assisted living facility areas and any licensed areas subject to another license type. (d) Upon approving an application for an assisted living facility license, the commissioner may issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility. An assisted living facility license for a campus must identify the address and licensed resident capacity of each building located on the campus in which assisted living services are provided.	0 100		

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0 100	Continued From page 2 (e) Upon approving an application for an assisted living facility license, the commissioner may: (1) issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility with dementia care, provided the assisted living facility for dementia care license for a campus identifies the buildings operating as assisted living facilities with dementia care; or (2) issue a separate assisted living facility with dementia care license for a building that is on a campus and that is operating as an assisted living facility with dementia care. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to manage, control, and/or operate the entire building as an assisted living facility. Non-assisted living occupants reside on one side of the duplex, and the licensee does not have access to all areas of the facility. 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: Upon arrival at the facility on September 15, 2025, at 1:00 p.m., the surveyor observed the	0 100		

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0 100	Continued From page 3 assisted living licensed facility was located in a building with two connected but separated dwellings units, sharing the same roof, with separate entrances and separate addresses. The address for the assisted living facility was 1544 Roundhouse Circle, Shakopee. The address for the connected duplex was 1548 Roundhouse Circle, Shakopee. On September 15, 2025, at 1:00 p.m., unlicensed personnel/manager (ULP/M)-C stated the owner and his family resided in the other side of the duplex. On September 18, 2025, the surveyor completed a tour of the facility from 12:30 p.m. until 2:35 p.m. with owner (O)-D and clinical nurse supervisor (CNS)-B. The property was observed to be a side-by-side duplex with the licensed facility operating from the West side of the property at 1544 Roundhouse Circle and a private unlicensed space at 1548 Roundhouse Circle on the East side. The building was split down the center separating these two halves of the building, with a shared wall in common between the 1544 and 1548 side. At approximately 1:00 p.m., CNS-B stated that O-D and their family live in the 1548 side of the property. At approximately 1:15 p.m., O-D confirmed they resided in the 1548 side of the property with their family. The surveyor requested documentation on the fire separation between the two halves of the building as required to properly separate the licensed facility from another occupancy. O-D was unable to provide documentation of fire ratings or occupancy separation. O-D stated they would request documentation of separation from the City of Shakopee. No further documentation has	0 100		

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0 100	Continued From page 4 been provided to the surveyor to verify separation. The surveyor further contacted the City of Shakopee and was unable to obtain evidence of separation. 144G.08 DEFINITIONS Subd. 7. Assisted living facility. Assisted living facility means a facility that provides sleeping accommodations and assisted living services to one or more adults. Assisted living facility includes assisted living facility with dementia care, and does not include: (1) emergency shelter, transitional housing, or any other residential units serving exclusively or primarily homeless individuals, as defined under section 116L.361; (2) a nursing home licensed under chapter 144A; (3) a hospital, certified boarding care, or supervised living facility licensed under sections 144.50 to 144.56; (4) a lodging establishment licensed under chapter 157 and Minnesota Rules, parts 9520.0500 to 9520.0670, or under chapter 245D, 245G, or 245I; (5) services and residential settings licensed under chapter 245A, including adult foster care and services and settings governed under the standards in chapter 245D; (6) a private home in which the residents are related by kinship, law, or affinity with the provider of services; (7) a duly organized condominium, cooperative, and common interest community, or owners' association of the condominium, cooperative, and common interest community where at least 80 percent of the units that comprise the condominium, cooperative, or common interest community are occupied by individuals who are	0 100		

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0 100	Continued From page 5 the owners, members, or shareholders of the units; (8) a temporary family health care dwelling as defined in sections 394.307 and 462.3593; (9) a setting offering services conducted by and for the adherents of any recognized church or religious denomination for its members exclusively through spiritual means or by prayer for healing; (10) housing financed pursuant to sections 462A.37 and 462A.375, units financed with low-income housing tax credits pursuant to United States Code, title 26, section 42, and units financed by the Minnesota Housing Finance Agency that are intended to serve individuals with disabilities or individuals who are homeless, except for those developments that market or hold themselves out as assisted living facilities and provide assisted living services; (11) rental housing developed under United States Code, title 42, section 1437, or United States Code, title 12, section 1701q; (12) rental housing designated for occupancy by only elderly or elderly and disabled residents under United States Code, title 42, section 1437e, or rental housing for qualifying families under Code of Federal Regulations, title 24, section 983.56; (13) rental housing funded under United States Code, title 42, chapter 89, or United States Code, title 42, section 8011; (14) a covered setting as defined in section 325F.721, subdivision 1, paragraph (b); or (15) any establishment that exclusively or primarily serves as a shelter or temporary shelter for victims of domestic or any other form of violence. Minnesota Statutes 144G.08 Definitions. Subdivision 59. "Resident" means an adult living	0 100		

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0 100	Continued From page 6 in an assisted living facility who has executed an assisted living contract. Subd. 59. Resident. Resident means an adult living in an assisted living facility who has executed an assisted living contract. Subd. 5. Assisted living contract. Assisted living contract means the legal agreement between a resident and an assisted living facility for housing and, if applicable, assisted living services. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 100		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the	0 470		

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0 470	Continued From page 7 requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a staffing plan that included an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility, and failed to have a daily work schedule posted in a central location, in accordance with Minnesota Administrative Rule 4659.0180, accessible to staff, residents, volunteers, and the public as required. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or 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 15, 2025, at 2:05 p.m. during a	0 470		

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0 470	Continued From page 8 tour of the facility with unlicensed personnel (ULP)-C, there was no staff schedule posting observed in the common areas of the facility. ULP-C stated there was no posted schedule. On September 15, 2025, at 3:15 p.m., licensed assisted living director/registered nurse(LALD/RN)-A stated the postings should have been on a wall by the living room and she would make sure they were put back up. She had been on vacation the past couple weeks and was unaware the postings had been taken down. The licensee's [licensee name] AL (assisted living) Staff Planning document was dated August 2, 2024. On September 16, 2025, at 2:02 p.m., clinical nurse supervisor (CNS)-B stated she was unaware the staffing plan needed to be updated twice a year and the staffing plan provided was the most current. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 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	0 480		

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0 480	Continued From page 9 certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 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	0 480		

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0 480	Continued From page 10 (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 September 15, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place	0 550		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 550	Continued From page 11 information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post in a conspicuous place, the required information about the facility's grievance procedure, contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, contact information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center, and a notice stating that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This 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	0 550		

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	38114	A. BUILDING: _____ B. WING _____	09/18/2025

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0 550	Continued From page 12 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 15, 2025, at 2:05 p.m. during a tour of the facility with unlicensed personnel (ULP)-C, there was no posting observed by the surveyor with information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. In addition, there was no posting observed by the surveyor that included the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center, or a notice stating that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health with that contact information. ULP-C stated there were no postings. On September 15, 2025, at 3:15 p.m., licensed assisted living director/registered nurse(LALD/RN)-A stated the postings should have been on a wall by the living room and she would make sure they were put back up. She had been on vacation the past couple weeks and was unaware the postings had been taken down.	0 550		

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0 550	Continued From page 13 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550		
0 570 SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the original current license at the main entrance of the facility. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when 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 15, 2025, at 2:05 p.m. during a tour of the facility with unlicensed personnel (ULP)-C, the surveyor observed the entrance of the facility and no license was posted. ULP-C stated she had taken it down until she could find a picture frame to put it in. On September 15, 2025, at 3:15 p.m., licensed assisted living director/registered nurse(LALD/RN)-A stated the license should	0 570		

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0 570	Continued From page 14 have been on a wall by the entrance to the facility and she would make sure they were put back up. She had been on vacation the past couple weeks and was unaware the postings had been taken down. The licensee's undated, Assisted Living Policy Manual indicated upon approval or renewal of license, the certificate of license will be hung in a frame in the main entryway corridor. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 570		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the 911 emergency number in common areas and near telephones provided by the assisted living facility,	0 640		

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0 640	Continued From page 15 and failed to post information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adults. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 15, 2025, at 2:05 p.m. during a tour of the facility with unlicensed personnel (ULP)-C, there was no posting observed by the surveyor of the 911 emergency number in common areas or by the telephone located in the living room of the facility. In addition, there was no posting observed with information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. ULP-C stated there were no postings. On September 15, 2025, at 3:15 p.m., licensed assisted living director/registered nurse(LALD/RN)-A stated the postings should have been on a wall by the living room and she would make sure they were put back up. She had been on vacation the past couple weeks and was unaware the postings had been taken down. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One	0 640		

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0 640	Continued From page 16 (21) days	0 640		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (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 establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for one of two employees (unlicensed personnel (ULP)-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	0 660		

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0 660	Continued From page 17 residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On September 17, 2025, at 7:20 a.m., the surveyor observed ULP-C administering medications to R1. ULP-C began providing direct care services for the licensee on December 5, 2024. ULP-C's employee file included a TB symptom screening dated December 5, 2024, and a TB blood test dated August 26, 2024. The blood test was not completed within 90 days prior to hire or upon hire as required. On September 16, 2025, at 10:05 a.m., licensed assisted living director/registered nurse (LALD/CNS)- stated she was unaware the TB test had to be within 90 days of hire The licensee's undated, Assisted Living Policy Manual in the Tuberculosis Prevention & Screening Plan section included the following: "Employees with written documentation of a previous positive TST or BAMT do not need a repeat TST or BAMT: - Assess for current TB symptoms - If they provide written documentation of the results of a chest x-ray indicating no active TB disease that is dated after the date of the positive TST or TB blood test result, they do not need another chest x-ray at the time of hire. - If they do not have the written documentation from above, they must receive a chest x-ray to exclude a diagnosis of infectious TB disease	0 660		

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0 660	Continued From page 18 before having direct patient contact." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
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	0 680		

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0 680	Continued From page 19 licensee failed to have a written emergency preparedness plan (EPP) with all the required content and failed to post the emergency plan. This had the potential to affect all residents, staff and visitors of the facility. 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 15, 2025, at 2:05 p.m. during a tour of the facility with unlicensed personnel (ULP)-C, the surveyor observed there was no emergency preparedness information in common areas of the facility or a posting to indicate where the emergency preparedness information could be found. ULP-C stated there was no emergency preparedness posting. The licensee provided a three ring binder labeled Emergency Preparedness Manual, last reviewed September 27, 2024. The EPP plan was received from a consulting group. The policies indicated the facility would have policies but they were not individualized to the facility. The emergency preparedness plan lacked evidence of the following required content: - missing resident plan last reviewed February 1, 2023; the plan was not reviewed quarterly as required; - identify at risk population needs like maintaining	0 680		

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0 680	Continued From page 20 independence, communication, transportation, supervision and medical care; - identify which staff would assume specific roles in another's absence through succession planning and delegation of authority; - identify a qualified person who is authorized in writing to act in the absence of the administrator; - policies to address food, medical supplies, and pharmaceutical supplies; - policy to address use of volunteers including the process/role for integration; and - emergency prep testing requirements for two full scale drills or one full scale drill and one tabletop exercise completed annually. On September 17, 2025, at 12:02 p.m., clinical nurse supervisor (CNS)-B reviewed the EPP plan and stated the required content was not in the EPP binder. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history,	0 730		

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0 730	Continued From page 21 allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	0 730		

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0 730	Continued From page 22 review, the licensee failed to ensure the resident record contained all the required content for the licensee's one active resident (R1) and the licensee's one discharged resident resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 was admitted on R1 On September 17, 2025, at 7:20 a.m., the surveyor observed unlicensed personnel (ULP)-C administering medications to R1. R1's Service Plan dated February 11, 2023, indicated R1 received services including medication management and administration, meal assistance, mental health symptom management, house keeping and laundry. R1's Service Recap Summary dated September 1-15, 2025, included staff initials for services completed. On September 3, 5, 7, 8, 9, 10, 11, 12, 13, and 14, there was missing documentation for one or more services provided. On September 17, 2025, at 8:30 a.m., clinical nurse supervisor (CNS)-B stated there was missing documentation for the services and staff	0 730		

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0 730	Continued From page 23 should have documented all services provided. R2 R2's record included Discharge/Transfer Summary printed September 16, 2025, indicated R2 was admitted on January 13, 2025, and was discharged to a nursing home on August 1, 2024. The Discharge/Transfer Summary had no indication a discharge summary had been provided to the resident, and with the resident's consent, the resident's representatives and case manager. The Summary did not include the following required content: A. a summary of the resident's stay that includes diagnoses, courses of illnesses, allergies, treatments and therapies, and pertinent lab, radiology, and consultation results; B. a final summary of the resident's status from the latest assessment or review under Minnesota Statutes, section 144G.70, if applicable, that includes the resident status, including baseline and current mental, behavioral, and functional status; C. a reconciliation of all pre-discharge medications with the resident's post discharge prescribed and over-the-counter medications; and D. a post discharge plan that is developed with the resident and, with the resident's consent, the resident's representatives, which will help the resident adjust to a new living environment. The Summary did not indicate where the resident plans to reside, any arrangements that have been made for the resident's follow-up care, and any post discharge medical and non-medical services the resident will need. On September 17, 2025, at 12:43 p.m., CNS-B stated she was unaware of the required content	0 730		

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0 730	Continued From page 24 in a discharge summary. The licensee's undated, Assisted Living Policy Manual, Resident Records section indicated the following would be in the resident record: - Documentation will be entered into the clinical record no later than two weeks after the end of the day service was provided; and - Discharge summary and related documentation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
0 775 SS=I	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 maintain facility in compliance with Minnesota State Fire Code under Minnesota Rules Chapter 7511. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 775		

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0 775	Continued From page 25 The findings include: On September 18, 2025, from approximately 12:30 p.m. to 2:35 p.m., the surveyor toured the facility with clinical nurse specialist (CNS)-B and owner (O)-D. During the tour the surveyor observed the following: A significant amount of cigarette butts was located on the ground and paver patio near the front entry to the facility. Dozens of cigarettes were not properly disposed of laying on the ground near the fence or in dry leaves near the plastic coffee container provided to contain discarded smoking materials. Cigarette butts should be removed from the ground and smoking materials must be properly disposed of to prevent fire risk. The stairs from the kitchen area were marked as an emergency exit, multiple objects were stored in the pathway of the stairs including propane. There was further a significant amount of construction materials, boards, concrete, and other items stored in the pathway to exit the yard. The gates leading out of the yard were not readily openable when attempted and access to the gates was obstructed by stored materials. CNS-B stated that the stairs and gates are not normally used and would not be usable to egress during emergency and would be difficult to access for emergency responders. Egress routes must be brought to and maintained in proper condition. Extension cords were in use in the living room to power the television and several other devices. Extension cords should not be used in lieu of permanent wiring.	0 775		

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	38114	A. BUILDING: _____ B. WING _____	09/18/2025

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0 775	Continued From page 26 Extension cords were in used in the garage powering a fridge and several tools. The extension cords were run under a door and showed evidence of damage and wear, which may pose electrocution or fire risk. Several power cords were connected together. Extension cords should not be used in lieu of permanent wiring. CNS-B and O-D acknowledged the noted deficiencies during the tour and expressed that they would correct the deficiencies. TIME PERIOD FOR CORRECTION: Two (2) days.	0 775		
0 780 SS=E	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and	0 780		

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0 780	Continued From page 27 (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide interconnected smoke alarms throughout the facility. 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, 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). Findings include: On September 18, 2025, from approximately 12:30 p.m. to 2:35 p.m., the surveyor toured the facility with clinical nurse specialist (CNS)-B and owner (O)-D. During the tour the surveyor observed the following: During the tour CNS-B tested smoke alarms by activating alarms in the upper-level bedroom hallway, and resident room 4. There were two	0 780		

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0 780	Continued From page 28 hardwired smoke alarms, located in the upper-level hallway and in the lower-level hallway, that did not connect with the wireless battery-operated smoke alarm system present in the facility. All smoke alarms in the facility must be interconnected such that the operation of any one smoke alarm causes all other supplied smoke alarms to sound. Provided hardwired alarms must also be maintained as hardwired. During the facility tour interview on September 18, 2025, O-D verified the above listed fire protection and physical environment observations while accompanying on the tour. and expressed that they would ensure interconnection and correct the deficiencies. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 800 SS=E	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. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation	0 800		

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0 800	Continued From page 29 with regard to the health, safety, and well-being of the residents. 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, 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 18, 2025, from approximately 12:30 p.m. to 2:35 p.m., the surveyor toured the facility with clinical nurse specialist (CNS)-B and owner (O)-D. During the tour the surveyor observed the following: The deck and railing off of the kitchen were not maintained in proper state of repair. Multiple posts and boards were rotten and damaged. The railing was not properly secured and was loose. The deck and stairs should be repaired and maintained in proper condition to avoid risk of fall. CNS-B acknowledged the noted deficiencies during the tour and expressed that they would correct the deficiencies. Later in the survey during interview, O-D was also informed of deficiencies and acknowledged required corrections would occur. TIME PERIOD FOR CORRECTION: Seven (7)	0 800		

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0 800	Continued From page 30 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 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.	0 810		

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0 810	Continued From page 31 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 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 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 18, 2025, at approximately 2:00 p.m.., clinical nurse specialist (CNS)-B provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. The licensee FSEP failed to include the following: Only one copy of the FSEP documents was available at the facility and it was located in a locked office in the basement where it would not be readily accessible in an emergency. The FSEP should be readily available at all times. The FSEP failed to include appropriate employee actions to take during a fire or similar emergency. The FSEP contained generic information provided by homecare consultants, but the FSEP did not have facility specific plans for evacuation.	0 810		

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0 810	Continued From page 32 The FSEP failed to identify specific fire protection actions for residents. There was no section in the provided documents that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. Fire procedures must be provided for residents CNS-B acknowledged they were not aware of any specific procedures for residents. Record review indicated the licensee failed to provide and document adequate training to employees on the FSEP upon hire and at least twice per year. Staff was unable to provide documentation showing adequate trainings were provided for employee training on the fire safety and evacuation plan. No documents were available of staff trainings on the FSEP. Staff should receive training upon hire and twice a year thereafter. Record review indicated the licensee failed to provide and document adequate training to residents on actions to take during a fire or evacuation. No documents were available of resident training. Residents should be provided training at least once a year. During an interview on September 19, 2025, at approximately 2:15 p.m.., the surveyor explained the requirements for employee trainings, resident trainings, and FSEP documentation. CNS-B stated they understood the requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		

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01440	Continued From page 33	01440		
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 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 observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted direct supervision of staff performing delegated nursing or therapy tasks within 30 days of first providing those services for one of one unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a	01440		

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01440	Continued From page 34 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-C was hired on December 5, 2024, to provide direct care services to residents. On September 17, 2025, at 7:20 a.m., the surveyor observed ULP-C administering medications to R1. ULP-C's record lacked evidence a supervisory visit for delegated tasks had been completed by a RN within 30 days of hire. On September 17, 2025, at 12:43 p.m., clinical nurse supervisor (CNS)-B stated ULP-C should have had the supervision completed within 30 days of providing delegated tasks. The licensee's undated, Assisted Living Policy Manual indicated all ULP will be supervised by a staff RN within 30 days of hire to ensure they are performing job duties competently. Staff RN's will continue to do supervisory visits of all ULP bi-annually after their initial 30 day supervisory visit. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		

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01530 SS=D	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to	01530		

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01530	Continued From page 36 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 received the required two hours of initial training on mental illness and de-escalation topics for one of two employees (unlicensed personnel lead (ULP)-C). This had the potential to affect all residents and staff. 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-C was hired on December 5, 2024, to provide direct care services to residents. On September 17, 2025, at 7:20 a.m., the surveyor observed ULP-C administering medications to R1. ULP-C's record lacked evidence of completing mental health and de-escalation training. On September 16, 2025, at 1:45 p.m., clinical nurse supervisor (CNS)-B stated all staff should	01530		

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01530	Continued From page 37 have had mental illness and de-escalation training. CNS-B further stated ULP-C did not have the required training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed	01620		

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01620	Continued From page 38 practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to complete a comprehensive assessment at least every 90 days as required for the licensee's one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect	01620		

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01620	Continued From page 39 a large portion or all of the residents). The findings include: R1 was admitted on February 2, 2023, and received direct care services. On September 17, 2025, at 7:20 a.m., the surveyor observed unlicensed personnel (ULP)-C administering medications to R1. R1's Service Plan dated February 11, 2023, indicated R1 received services including medication management and administration, meal assistance, mental health symptom management, house keeping and laundry. R1's record identified the following assessments: - Clinical Update Assessment dated January 28, 2025; - Clinical Update Assessment dated May 3, 2025, this was 95 days between assessments; and - Clinical Update Assessment dated August 16, 2025, this was 105 days between assessments. On September 17, 2025, at 8:30 a.m., clinical nurse supervisor (CNS)-B stated the assessments were completed late and should have been completed within 90 days. The licensee's undated, Assisted Living Policy Manual, under the section Acceptance of Residents, indicated reassessments shall be conducted as needed or no longer than 90 days from the previous assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38114	A. BUILDING: _____ B. WING _____	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLISTIC HEALTH CARE SERVICES LLC	1544 ROUNDHOUSE CIRCLE SHAKOPEE, MN 55379

(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
01620	Continued From page 40 (21) days	01620		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the licensee's medications were securely locked permitting only authorized personnel to have access. This had the potential to affect all residents residing within the facility. 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 September 15, 2025, at 2:05 p.m. during a facility tour with ULP-C, the surveyor observed the locked medication closet had the keys to the door hanging in the lock. On September 15, 2025, at 3:15 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated staff should be carrying the key at all times and not leave it in the lock.	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38114	A. BUILDING: _____ B. WING _____	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLISTIC HEALTH CARE SERVICES LLC	1544 ROUNDHOUSE CIRCLE SHAKOPEE, MN 55379

(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
01880	Continued From page 41 The licensee's undated, Assisted Living Policy Manual, under a section titled Storage of Medications, indicated all medications will be stored in a locked container that is only accessible to [license name] staff with prior authorization. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by:	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38114	A. BUILDING: _____ B. WING _____	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLISTIC HEALTH CARE SERVICES LLC	1544 ROUNDHOUSE CIRCLE SHAKOPEE, MN 55379

(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
01910	Continued From page 42 Based on interview and record review, the licensee failed to include all required information on the disposition of medications for the licensee's one discharged resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2's Care Coordination Notes dated August 1, 2024, included documentation that R2 was moved to a long term care facility closer to her family. The document included a list of medications give to the family. The list of medications included the name of the medication, the strength, the directions for use, and the quantity of medications. The document did not include prescription numbers for the medications. On September 17, 2025, at 8:30 a.m., clinical nurse supervisor (CNS)-B stated she was unaware the documentation of prescription numbers was required. The licensee's undated, Assisted Living Policy Manual, a section titled Disposition of Meds (Medications) did not include what information the documentation of medication disposition would include.	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38114	A. BUILDING: _____ B. WING _____	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLISTIC HEALTH CARE SERVICES LLC	1544 ROUNDHOUSE CIRCLE SHAKOPEE, MN 55379

(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
01910	Continued From page 43 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		

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

HOLISTIC HEALTH CARE SERVICES
1544 ROUNDHOUSE CIRCLE
Shakopee, MN 55379
Scott County
Parcel:

Phone:

License Info

License: HFID 38114

Risk:
License:
Expires on:
CFPM: Ridwan A. Mohamed
CFPM #: 108139; Exp: 10/8/2027

Inspection Info

Report Number: F8041251128
Inspection Type: Follow-up - Single
Date: 9/29/2025 Time: 12:00 PM
Duration: minutes
Announced Inspection:
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

Follow-up inspection was completed to assess compliance with previous orders. All previous orders have been corrected.

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 F8041251128 from 9/29/2025

Jijo Ahmed

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

HOLISTIC HEALTH CARE SERVICES
Shakopee
County/Group: Scott County

Inspection Info

Report Number: F8041251128
Inspection Type: Follow-up
Date: 9/29/2025
Time: 12:00 PM

Food Temperature: Product/Item/Unit: milk**; Temperature Process:** Cold-Holding
Location: kitchen refrigerator at 34 Degrees F.
Comment:
Violation Issued?: No

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

Sanitizer Observations/Recordings

Establishment Info

HOLISTIC HEALTH CARE SERVICES
Shakopee
County/Group: Scott County

Inspection Info

Report Number: F8041251128
Inspection Type: Follow-up
Date: 9/29/2025
Time: 12:00 PM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Kitchen **Equal To** 160 Degrees F.
Comment:
Violation Issued?: No

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

HOLISTIC HEALTH CARE SERVICES
1544 ROUNDHOUSE CIRCLE
Shakopee, MN 55379
Scott County
Parcel:

Phone:

License Info

License: HFID 38114

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

Inspection Info

Report Number: F8041251122
Inspection Type: Full - Joint
Date: 9/15/2025 Time: 1:00 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 4
Total Priority 2 Orders: 2
Total Priority 3 Orders: 3
Delivery: Emailed

New Order: 2-100 Supervision
2-102.12AMN *Priority Level: Priority 3 CFP#: 2*
MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.
COMMENT: FACILITY DOES NOT HAVE A CERTIFIED FOOD PROTECTION MANAGER. OPERATOR IS WORKING ON COMPLETED A FOOD SAFETY COURSE AND WILL APPLY FOR A STATE (CFPM) CERTIFICATE. LINK TO APPLICATION SENT WITH REPORT.
Comply By: 9/15/2025 Originally Issued On: 9/15/2025

! **New Order: 2-200 Employee Health**
2-201.11C *Priority Level: Priority 1 CFP#: 3*
MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.
COMMENT: FACILITY DOES NOT HAVE AN EMPLOYEE ILLNESS LOG. EXCLUSION AND LOGGING REQUIREMENTS REVIEWED DURING INSPECTION. MDH LOG FORM SENT WITH REPORT.
Comply By: 9/15/2025 Originally Issued On: 9/15/2025

! **New Order: 3-300B Protection from Contamination: cross-contamination, eggs**
3-302.11A(1) *Priority Level: Priority 1 CFP#: 15*
MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.
COMMENT: UNPASTEURIZED SHELL EGGS AND RAW CHICKEN STORED ABOVE READY-TO-EAT FOODS IN THE REFRIGERATOR. CORRECTED ON SITE. SHELL EGGS AND CHICKEN WERE MOVED TO THE LOWER DRAWER IN THE REFRIGERATOR TO PREVENT CROSS CONTAMINATION.
Comply By: 9/15/2025 Originally Issued On: 9/15/2025

New Order: 3-400A Destroying Organisms: cooking time/temperature, freezing
3-401.11D(1) & (2) *Priority Level: Priority 3 CFP#: 18*
MN Rule 4626.0340D(1)(2) Discontinue offering raw or undercooked fish, shellstock, eggs, steak tartar or comminuted beef to a highly susceptible population which includes children.
COMMENT: EGGS ARE SERVED UNDERCOOKED (OVER EASY) PER REQUEST. FACILITY USES UNPASTEURIZED EGGS. EGGS MUST BE FULLY COOKED. DISCUSSED PURCHASING PASTEURIZED SHELL EGGS.
Comply By: 9/15/2025 Originally Issued On: 9/15/2025

! **New Order: 3-500B Microbial Control: hot and cold holding**
3-501.16A2 *Priority Level: Priority 1 CFP#: 22*
MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.
COMMENT: TCS FOODS IN THE KITCHEN REFRIGERATOR MEASURED 49-54 DEG. F. FOOD WAS DISCARDED DURING INSPECTION.
Comply By: 9/15/2025 Originally Issued On: 9/15/2025

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 PACKAGES OF HOT DOGS, MILK AND TURKEY NOT DATE MARKED. DATE MARKING REQUIREMENTS REVIEWED DURING INSPECTION.
Comply By: 9/15/2025 Originally Issued On: 9/15/2025

New Order: 4-300 Equipment Numbers and Capacities
4-302.12B *Priority Level: Priority 2 CFP#: 36*
MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.
COMMENT: FACILITY DOES NOT HAVE FOOD THERMOMETER.
Comply By: 9/22/2025 Originally Issued On: 9/15/2025

New Order: 4-500 Equipment Maintenance and Operation
4-501.11AB *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.
COMMENT: THE KITCHEN REFRIGERATOR IS NOT MAINTAINING TCS FOODS AT PROPER TEMPERATURE. ADJUST, REPAIR OR REPLACE THIS COOLER. DISCUSSED USING SMALL REFRIGERATOR LOCATED OUTSIDE OF THE KITCHEN TO STORE TCS FOODS UNTIL THE KITCHEN REFRIGERATOR IS REPAIRED.
Comply By: 9/15/2025 Originally Issued On: 9/15/2025

! **New Order: 4-700 Sanitizing Equipment and Utensils**
4-703.11B *Priority Level: Priority 1 CFP#: 16*
MN Rule 4626.0905B Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.
COMMENT: DISHWASHER DID NOT ACHIEVE A UTENSIL SURFACE TEMPERATURE OF AT LEST 160 F WHEN TESTED. PER OPERATOR, THE DISHWASHER MAY NOT HAVE BEEN ON HIGH TEMP. CYCLE AND WILL BE RETESTED. USE ALTERNATIVE METHOD FOR SANITIZING UNTIL DISHWASHER IS VERIFIED TO REACH AT LEAST 160 F FOR SANITIZING.
Comply By: 9/15/2025 Originally Issued On: 9/15/2025

Food & Beverage General Comment

Inspection was completed with Jijo Ahmed (owner) and Nicholas Streeter (MDH). Stacy Haag was the lead Health Regulation Division Nurse Evaluator. Facility had 1 residents at time of inspection.

This establishment has a residential kitchen and food is prepared for same day service only. The kitchen has wood cabinets with a hollow base and solid surface countertop, a popcorn ceiling and wood flooring.

A two basin sink is located in the kitchen with one basin designed for handwashing. Frigidaire (NSF residential) dish machine has a sanitizing cycle option. Verify the dish machine achieves a utensil surface temperature of 160

Deg. F 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 F8041251122 from 9/15/2025

Jijo Ahmed
Owner

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

HOLISTIC HEALTH CARE SERVICES
Shakopee
County/Group: Scott County

Inspection Info

Report Number: F8041251122
Inspection Type: Full
Date: 9/15/2025
Time: 1:00 PM

Food Temperature: Product/Item/Unit: hot dog**; Temperature Process:** Cold-Holding
Location: kitchen refrigerator at 49 Degrees F.
Comment:
Violation Issued?: Yes

Food Temperature: Product/Item/Unit: turkey**; Temperature Process:** Cold-Holding
Location: kitchen refrigerator at 54 Degrees F.
Comment:
Violation Issued?: Yes

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

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

Sanitizer Observations/Recordings

Establishment Info

HOLISTIC HEALTH CARE SERVICES
Shakopee
County/Group: Scott County

Inspection Info

Report Number: F8041251122
Inspection Type: Full
Date: 9/15/2025
Time: 1:00 PM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Kitchen **Equal To** 150 Degrees F.
Comment:
Violation Issued?: Yes