Electronically Delivered

October 14, 2025

Licensee
Lakeland Health Services LLC
11840 Foley Boulevard Northwest
Coon Rapids, MN 55448

RE: Project Number(s) SL39587016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 10, 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 . . ."

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 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
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.

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,

Kelly Thorson

Kelly Thorson, Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39587	A. BUILDING: _____ B. WING _____	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND HEALTH SERVICES LLC	11840 FOLEY BOULEVARD NW COON RAPIDS, MN 55448

(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: SL39587016 On September 8, 2025, through September 10, 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 two residents; both receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance 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 surveyors' 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 subd. 1, 2, and 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 September 9, 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		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control and current recommendations for hand hygiene and administration of injections. This had the potential to affect all the licensee's 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 the potential to affect a large portion or all	0 510		

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0 510	Continued From page 4 the residents). The findings include: On September 8, 2025, at 3:00 p.m., the surveyor observed clinical nurse supervisor (CNS)-B administer R2's Ozempic (diabetes medication) injection. CNS-B checked the electronic medication administration record (EMAR) and compared it to the medication and performed hand hygiene. CNS-B cleansed R2's abdomen, applied a needle to the Ozempic injector pen without first cleansing the hub, primed two units, administered 2mg as ordered, disposed of the needle, performed hand hygiene, and documented the administration. On September 9, 2025, at 7:45 a.m., the surveyor observed unlicensed personnel (ULP)-C administer oral medications to R3. ULP-C performed hand hygiene, donned gloves, compared medications to the EMAR, gave R3 his oral medications with water without issue, doffed gloves, and documented the medication administration. ULP-C failed to perform hand hygiene after doffing the gloves. ULP-C stated she would usually wash her hands when she got back upstairs and does usually wash hands after taking off gloves but was nervous today from being watched. On September 10, 2025, at 10:30 a.m., CNS-B stated ULP's are trained to perform hand hygiene both before donning gloves and after doffing gloves. CNS-B further stated normal practice is to cleanse the hub of an injection pen before applying a needle but just forgot that time. The Center of Disease Control (CDC) Core	0 510		

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0 510	Continued From page 5 Infection Prevention and Control Practices regarding hand hygiene dated November 29, 2022, recommends healthcare personnel should use an alcohol-based rub or wash with soap and water for the following clinical indications: immediately before touching a patient, before performing aseptic task or handling invasive medical devices, before moving from work on a soiled body site to a clean body site on the same patient, after touching a patient or the patient's immediate environment, after contact with blood, body fluids, or contaminated services, and immediately after glove removal. The licensee's undated Handwashing policy indicated when conducting a procedure requiring the use of gloves, proper hand hygiene should be completed before donning gloves and after removing gloves. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
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	0 660		

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0 660	Continued From page 6 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 observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test for one of one employee 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, 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: The facility TB risk assessment completed March 4, 2025, indicated the facility was at a low risk for TB transmission. ULP-C began employment on May 12, 2025, to provide direct care services. On September 9, 2025, the surveyor observed ULP-C administer medications to R3.	0 660		

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0 660	Continued From page 7 ULP-C's record lacked evidence the second step of the two-step Mantoux was completed. On September 9, 2025, at 10:30 a.m., licensed assisted living director (LALD)-A stated most of the staff have the blood test done and did not know ULP-C had gone in for the two-step Mantoux instead of the blood test so did not realize the second step had not been completed. The Minnesota Department of Health guidelines Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include an annual facility TB risk assessment. The guidelines also indicated an employee may begin working with patients (residents) after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients. Baseline TB screening should be documented in the employee's record. The licensee's Tuberculosis Screening/Prevention policy dated February 16, 2023, indicated baseline testing is completed on hire for all direct care providers. The baseline test may be either TST (2-step) or BAMT. If the first step is negative, the second step TST will be administered 1-3 weeks after the first TST result was read. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 660		

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0 660	Continued From page 8 (21) days	0 660		
0 775 SS=D	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the requirements of Minnesota State Fire Code Rules, Chapter 7511. 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: On September 9, 2025, at 3:30 p.m., the surveyor toured the facility with licensed assisted living director (LALD)-A. During the facility tour, the surveyor observed 2 holes in the garage wall between the occupied assisted living dwelling unit and the attached garage. During the facility tour interview, LALD-A verified the above listed observations and stated these holes would be repaired. The fire-resistant drywall between the assisted living dwelling unit and attached garage shall be maintained free of holes and sealed to prevent the passage of smoke or fire from one	0 775		

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0 775	Continued From page 9 side of the wall to the other. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 780 SS=F	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 (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	0 780		

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0 780	Continued From page 10 by: Based on observation and interview, the licensee failed to provide smoke alarms that complied with fire protection requirements. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 9, 2025, at 3:30 p.m., the surveyor toured the facility with licensed assisted living director (LALD)-A. During the facility tour, the surveyor observed when the smoke alarms on the main floor were tested, the smoke alarms in the basement were not actuated. When then basement smoke alarms were tested, the smoke alarms installed on the main floor were not actuated. During the facility tour interview, LALD-A verified the smoke alarm observations. All smoke alarms installed in the dwelling unit must be interconnected so actuation of one alarm causes all alarms in the dwelling unit to operate. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and	0 810		

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0 810	Continued From page 11 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. 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,	0 810		

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	39587	A. BUILDING: _____ B. WING _____	09/10/2025

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0 810	Continued From page 12 make all parts of the plan readily available, and provide required training and drills. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 9, 2025, licensed assisted living director (LALD)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The FSEP failed to identify the location of a resident sleeping room and accurately identify emergency exit and portable fire extinguisher locations evident by the following: On September 9, 2025, at 3:30 p.m., the surveyor toured the facility with licensed assisted living director (LALD)-A. During the facility tour, the surveyor observed the following: - During the facility tour interview, LALD-A verbally identified resident room 3 on the main floor. A number identifier was not posted at this resident sleeping room door. Number identifiers are required to be posted at all sleeping room doors. The numbers installed at the resident room doors must correspond with the FSEP floor plans to provide efficient communication for exiting in the event of a fire or similar emergency.	0 810		

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0 810	Continued From page 13 - The FSEP floor plan labeled an emergency exit leading into the attached garage. Emergency exits are required to lead directly to the exterior of the building and not through a higher-hazard room. - The FSEP floor plan labeled an emergency exit leading from the dining room out to a deck enclosed by railings. All paths of egress must provide unobstructed exiting. - A fire extinguisher was mounted on the wall in the kitchen. The FSEP floor plan labeled the main floor fire extinguisher location in the dining room. The location of the main floor fire extinguisher was not accurately identified. During the facility tour interview, LALD-A verified the FSEP floor plans required revision. Record review of the available documentation indicated the licensee failed to develop and maintain the FSEP with site specific procedures for the facility and building occupants evident by the following: The FSEP had been created using templates from third party providers. - In the emergency preparedness binder, the policy titled fire safety and evacuation plan dated April 1, 2024, included procedures developed for a building with life safety systems and fire resistant construction type that were not applicable to a residential home. Smoke compartments, fire doors, magnetic door holders, and a fire alarm system with an automatic dialer that notifies a monitoring company were inaccurately referenced. The building occupants were inappropriately instructed to only evacuate upon orders from the administration or fire department. - The FSEP included standard employee	0 810		

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0 810	Continued From page 14 procedures for fire safety, but 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 employee actions were limited to the RACE (Remove, Alarm, Confine, Extinguish/Evacuate) acronym. Pull fire alarms were inaccurately referenced. - The FSEP failed to include fire safety and evacuation instructions for residents evident by a lack of these procedures in the plan. The resident instructions were limited to directing residents to stoop or crawl to avoid smoke. No additional fire protection procedures necessary for residents were included. - The FSEP included standard resident evacuation procedures, but failed to provide site specific actions for resident movement and evacuation or relocation during a fire or similar emergency evident by a lack of these procedures in the plan. During an interview on September 9, 2025, at 4:20 p.m., LALD-A verified the FSEP required revision. All parts of the FSEP were not maintained as readily available for accessibility evident by the following: - Record review indicated the FSEP did not include evacuation procedures for the individualized unique needs of residents. During an interview on September 9, 2025, at 4:20 p.m., LALD-A stated residents requiring staff assistance in an emergency had been identified in their care plans and these procedures were maintained electronically on the computer. These	0 810		

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0 810	Continued From page 15 individualized evacuation procedures were not included with the printed copy of the FSEP. - On September 9, 2025, at 3:30 p.m., the surveyor toured the facility with licensed assisted living director (LALD)-A. During the facility tour, the surveyor observed the fire safety and evacuation plan policy dated April 1, 2024, was not posted in the facility. Record review indicated the fire safety and evacuation plan policy dated April 1, 2024, was stored in the emergency preparedness binder. During an interview on September 9, 2025, at 4:20 p.m., LALD-A stated this binder was kept in the employee office located in the basement, that was sometimes kept locked. LALD-A stated the emergency floor plans and fire safety information were posted in common areas of the building. TRAINING Record review indicated the licensee failed to provide fire safety and evacuation training to residents at least once per year evident by a review of training documentation lacking the required frequency. One record for resident fire safety and evacuation training dated May 9, 2024, was provided. No additional training records were provided. During an interview on September 9, 2025, at 4:20 p.m., LALD-A verified the training frequency was not met and stated residents were trained at the time of move in and during fire drills. Record review indicated the licensee failed to provide training to employees on the FSEP at least twice per year evident by a review of training documentation lacking the required frequency. One training record, titled fire safety evacuation, was provided. During an interview on	0 810		

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0 810	Continued From page 16 September 9, 2025, at 4:20 p.m., LALD-A stated this record documented both annual and new hire employee training. LALD-A verified the training frequency was not met. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month evident by a review of completed fire drill logs lacking the required documentation and frequency. Four fire drills were recorded in 2025. Drills were completed in January, March, May, and July. The time or shift of the January and March drills had not been recorded. Additionally, the time or shift was not recorded on the 2024 November, September, and July drill logs. During an interview on September 9, 2025, at 4:20 p.m., LALD-A verified the evacuation drill frequency was not met and the required documentation not maintained. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 830 SS=E	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements, except a facility with a licensed resident capacity of six or fewer is exempt from rental licensing regulations imposed by any town, municipality, or county.	0 830		

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0 830	Continued From page 17 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to obtain a building permit and submit a Minnesota Department of Health engineering services plan review application for facility construction projects. 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 9, 2025, at 3:30 p.m., the surveyor toured the facility with licensed assisted living director (LALD)-A. During the facility tour, the surveyor observed the following: - A ramp constructed of wood was installed on the exterior of the building, leading from the driveway up to the front door. A landing was not installed at the top of the ramp. During the facility tour interview, LALD-A stated the ramp had been installed two years ago. - New doors, that required modifications to the door frame width, had been installed for resident sleeping room 3 and the main floor bathroom. During the facility tour interview, LALD-A stated the doors had been installed a few months ago to make these rooms more accessible.	0 830		

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0 830	Continued From page 18 During the facility tour interview, the surveyor requested copies of the local building permits for these projects from LALD-A. Copies of these permits were not provided. Additionally, record review indicated plan review applications were not submitted to Minnesota Department of Health engineering services for these projects. TIME PERIOD FOR CORRECTION: Seven (7) days	0 830		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating;	01370		

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01370	Continued From page 19 (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview and, record review, the licensee failed to ensure required training was completed for one of one employee (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, 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 began employment on May 12, 2025, to provide direct care services to residents. On September 9, 2025, at 7:45 a.m. the surveyor observed ULP-C administer medications to R3.	01370		

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01370	Continued From page 20 ULP-C's employee record lacked documentation of the following required training to be completed by ULP: -documentation requirements for all services provided -training on the prevention of falls for providers working with the elderly or individuals at risk of falls -understanding appropriate boundaries between staff and residents and the resident's family On September 10, 2025, at 10:45 a.m. licensed assisted living director (LALD)-A stated ULP-C was assigned the training but had not completed it. The licensee's Staff Competency policy dated February 16, 2023, indicated training and competency evaluations for all unlicensed personnel include the following: -documentation requirements for all services provided -training on the prevention of falls for providers working with the elderly or those at risk of falls -understanding appropriate boundaries between staff, residents and the resident's family No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include:	01380		

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01380	Continued From page 21 (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview and, record review, the licensee failed to ensure required training was completed for one of one employee (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, 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 began employment on May 12, 2025, to provide direct care services to residents. On September 9, 2025, at 7:45 a.m. the surveyor observed ULP-C administer medications to R3.	01380		

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01380	Continued From page 22 ULP-C's employee record lacked documentation of the following required training to be completed by ULP: -recognizing physical, emotional, cognitive, and developmental needs of the resident On September 10, 2025, at 10:45 a.m. licensed assisted living director (LALD)-A stated ULP-C was assigned the training but had not completed it. The licensee's Staff Competency policy dated February 16, 2023, indicated training and competency evaluations for all unlicensed personnel include the following: -recognizing physical, emotional, cognitive and developmental needs of the resident No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure documentation of medication setup included all the required content for one of one resident (R2).	01770		

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01770	Continued From page 23 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 the residents). The findings include: R2's record lacked medication set-up documentation to include dates of medication setup and the name of the person completing the medication setup. On September 10, 2025, at 10:05 a.m., clinical nurse supervisor (CNS)-B stated she was not aware of all the documentation requirements for medication setups. The licensee's Medication Documentation policy dated February 16, 2023, indicated [the facility] will document medication setup according to the following: -date of medication setup -name of medication -quantity of dose -times to be administered -route of administration -name/title of person completing medication setup No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		

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01790 SS=D	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in	01790		

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01790	Continued From page 25 the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. 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) developed training and competencies for unlicensed personnel (ULP) providing medications to residents for unplanned time away from home when the licensed nurse was not available for one of one employee (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, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a	01790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39587	A. BUILDING: _____ B. WING _____	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND HEALTH SERVICES LLC	11840 FOLEY BOULEVARD NW COON RAPIDS, MN 55448

(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
01790	Continued From page 26 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 began employment on May 12, 2025, to provide direct care services to residents. On September 9, 2025, at 7:45 a.m. the surveyor observed ULP-C administer medications to R3. ULP-C's employee record lacked documentation of training and competencies for unplanned time away when the RN was not available. On September 10, 2025, at 10:47 a.m., clinical nurse supervisor (CNS)-B stated they did not have ULP-C train or show competency for providing medications to residents for unplanned times away. This training was included with the old training platform but not with the new one and it was missed. The licensee's Medication Management Plan for Residents Away from Home policy dated February 16, 2023, indicated the RN has trained the ULPs and determined the unlicensed personnel competency to follow procedures for giving medications to residents. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39587	A. BUILDING: _____ B. WING _____	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND HEALTH SERVICES LLC	11840 FOLEY BOULEVARD NW COON RAPIDS, MN 55448

(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
01890	Continued From page 27 immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure time sensitive medications included the opened or expiration date. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On September 8, 2025, at 3:00 p.m., the surveyor observed clinical nurse supervisor (CNS)-B administer an Ozempic (diabetic medication) injection for R2. R2's Ozempic pen was not labeled with an opened or expiration date. Manufacturer's instructions for Ozempic indicated injection pens should be disposed of 56 days after opening. On September 10, 2025, at 10:39 a.m., CNS-B stated they would typically label injection pens	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39587	A. BUILDING: _____ B. WING _____	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND HEALTH SERVICES LLC	11840 FOLEY BOULEVARD NW COON RAPIDS, MN 55448

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01890	Continued From page 28 with opened dates but forgot this time. The licensee's Storage/Control of Medications policy dated February 16, 2023, indicated the medication label should contain the following-expiration date for time-sensitive drugs. The licensed nurse is responsible for dating time-sensitive medications when opened. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

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

LAKELAND HEALTH SERVICES LLC
11840 FOLEY BOULEVARD NW
Coon Rapids, MN 55448
Anoka County
Parcel:

Phone:

License Info

License: HFID 39587

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

Inspection Info

Report Number: F1036251108
Inspection Type: Full - Single
Date: 9/9/2025 Time: 11:23:40 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 1
Total Priority 2 Orders: 1
Total Priority 3 Orders: 2
Delivery:

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: Operator completed the educational class and proctored exam. Provide evidence of exam completion with application for CPFM (Search MDH CFPM for application and information). Post CFPM certificate when acquired.
Comply By: 9/9/2025 Originally Issued On: 9/9/2025

! **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: No Employee illness log on site. Example MDH illness log sent to establishment along with report.
Comply By: 9/9/2025 Originally Issued On: 9/9/2025

New Order: 4-200 Equipment Design and Construction
4-201.11GMN *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0506G Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.
COMMENT: Observed leftover egg bake in the fridge. Since equipment is not commercial grade, all food must be for same day service and leftovers can never be saved. Item discarded on site.
Comply By: 9/9/2025 Originally Issued On: 9/9/2025

New Order: 4-300 Equipment Numbers and Capacities
4-302.13A *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0710A Provide a readily accessible temperature measuring device for measuring the washing and sanitizing temperatures in manual warewashing operations.
COMMENT: Provide a means of verifying the internal contact temperature during the dish washer sanitizing cycle
Comply By: 9/9/2025 Originally Issued On: 9/9/2025

Food & Beverage General Comment

Handles for cabinets clean to sight and touch during inspection, but 1970's ornate style with hollow backs; recommend replacing with cabinet handles that are smooth, durable, and are easy to clean (e.g. like the microwave handle)

SINK USAGE
Facility has a two (2) compartment sink
Facility has a dishwasher with NSF 184 certification for sanitation
Facility does not have a 3 compartment sink
Facility does not have a dedicated food preparation sink

FACILITY
Kitchen has laminate floor, laminate countertops, stained wood cabinets, hollow enclosed cabinet bases
Appliances are residential
COUNTERTOPS AND FOOD CONTACT SURFACES
Provide a smooth, non-porous food contact surface (e.g. cutting boards) that can be easily washed, rinsed, and sanitized (e.g. run through the dishwasher). Soap and water can be used to clean non-food contact surfaces. By provided a cutting board or other non-porous food contact surface, the countertops can be kept clean without the use of substances which may damage the finish. Do not use wood as a food contact surface.
Plastic cutting board available

DISHWASHING – NSF 184
Dishwasher has a sanitizing rinse option (NSF/ANSI Standard 184) – use this option to sanitize utensils
Provide a means of testing the internal contact temperature of utensil in the dishwasher
If the sanitize cycle on the dishwasher will not be used, provide an alternate means of chemical sanitizing (e.g. a bus tub or other basin, to be filled with water and sanitizing solution e.g. chlorine bleach (non-scented, labeled for Sanitizing Food Contact Surfaces) at 50-100 PPM; provide a test kit for chemical sanitizing)
Recommend having an alternative means of sanitizing available case of emergency or service interruption

EQUIPMENT
MN 4626.0506 includes alternate equipment and finish requirements for adult care facilities which serve TCS foods for same-day service only:
MN 4626.0506 G. A food establishment that is an adult care center, child care center, or boarding establishment does not need to comply with item A [certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program for food service equipment] if approved by the regulatory authority and the food establishment:
(1) serves only non-TCS food; or
(2) prepares TCS foods only for same-day service.
Discontinue any service of TCS food for multiple day service (e.g. cooling and reservice of leftovers of prepared and cooked TCS food), or upgrade finishes and equipment in the kitchen
GENERAL COMMENTS
CFPM (Certified Food Protection Manager)
For information, please search "MDH CFPM"
Discussed employee health and hygiene, exclusion for individuals from the kitchen with vomiting and/or diarrheal illness, sore throat with fever, or reportable illness; food cooking and holding temperatures, cross-contamination, allergens, food storage order in refrigerator, separating resident food from medication or staff food, avoiding bare hand contact with foods which will not be cooked (cut fruit, deli sandwiches), pest

control, quarantine meals
Date marking TCS foods (when packages are opened or food is prepared, date mark and discard after 7 days, except for certain cultured dairy products)
Chemical label, use, and storage
Discussed food source, recalls, and refusing food which has signs of tampering or temperature abuse
Information on food recalls available "MDA Food Recall"
https://www.mda.state.mn.us/food-feed/food-recalls-consumer-advisories-minnesota

FACT SHEETS
Please search "MDH Fact Sheets" for the Food Business fact sheets page
"Cleaning and Sanitizing" https://www.health.state.mn.us/communities/environment/food/docs/fs/cleansanfs.pdf
"Food Cooking Temperatures"
https://www.health.state.mn.us/communities/environment/food/docs/fs/timetempfs.pdf
"Date Marking TCS foods"
https://www.health.state.mn.us/communities/environment/food/docs/fs/datemarkingfs.pdf
"Highly Susceptible Populations" - no service or raw or undercooked animal food, use Pasteurized eggs when preparing eggs raw or undercooked or batching scrambled eggs
https://www.health.state.mn.us/communities/environment/food/docs/fs/highsuspopfs.pdf

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 F1036251108 from 9/9/2025

Jeff Johanson

Urji Gamada
Person in Charge

Jeff Johanson,
Public Health Sanitarian 1
651-201-4349
jeff.johanson@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

LAKELAND HEALTH SERVICES LLC
Coon Rapids
County/Group: Anoka County

Inspection Info

Report Number: F1036251108
Inspection Type: Full
Date: 9/9/2025
Time: 11:23:40 AM

Equipment Temperature: Product/Item/Unit: Fridge**; Temperature Process:** Ambient Air
Location: Kitchen at 36 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: Freezer**; Temperature Process:** Ambient Air
Location: Kitchen at 4 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

LAKELAND HEALTH SERVICES LLC
Coon Rapids
County/Group: Anoka County

Inspection Info

Report Number: F1036251108
Inspection Type: Full
Date: 9/9/2025
Time: 11:23:40 AM

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