Electronically Delivered

May 28, 2026

Licensee
Eden Health Care LLC
219 106th Avenue Northwest
Coon Rapids, MN 55448

RE: Project Number(s) SL41330015

Dear Licensee:

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

The Minnesota Department of Health completed an initial survey on April 15, 2026, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement;
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00
St - 0 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - $500.00

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

The correction order documentation should include the following:

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

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

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

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

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Kelly Thorson

Kelly Thorson, Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.us
Telephone: 320-223-7336 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
	41330	A. BUILDING: _____ B. WING _____	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDEN HEALTH CARE LLC	219 106TH AVE 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: SL41330015-0 On April 13, 2026, through April 15, 2026, 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 resident was receiving services under the Provisional Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated April 13, 2026, 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	0 480		

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0 480	Continued From page 3 to the FBEIR for any compliance dates.	0 480		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of one residents (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 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: R1 was admitted to the licensee, and began	0 630		

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0 630	Continued From page 4 receiving assisted living services on February 28, 2025. R1's record included a [Lisensee] Assisted Living Contract. signed by R1 on February 28, 2025. R1's record included an individualized review or assessment of the resident's susceptibility to abuse by other individuals, and the specific measures to be taken to minimize the risk of abuse to the resident, however, R1's record lacked an individualized review or assessment of the resident's susceptibility to abuse other vulnerable adults and the specific measures to be taken to minimize the risk of abuse to other vulnerable adults. On April 14, 2026, at 11:38 a.m., clinical nurse supervisor (CNS)-D stated, "I was not aware that was needed, and I will incorporate that going forward." The licensee's Vulnerable Adult Policy, dated January 15, 2026, indicated, "An individual abuse prevention plan shall be established for each vulnerable minor or adult for whom assisted living services are provided. 1) The plan shall contain an individualized assessment of the resident ' susceptibility to abuse by another individual, including other vulnerable adults 2) The plan shall contain the resident's risk of abusing other vulnerable adults 3) The plan shall contain statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		

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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 observation, interview, and record review, the licensee failed to ensure screenings for active TB (either a two-step tuberculin skin test (TST) or blood test) were completed and documented for one of three employees (unlicensed personnel (ULP)-F). 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	0 660		

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0 660	Continued From page 6 The findings include: ULP-F had a hire date of June 24, 2025, and provided direct care services to residents. ULP-F's employee records lacked evidence of screening for active TB with either a two-step TST or blood test. On April 13, 2026, at 11:45 a.m., surveyor observed ULP-F administer medication to R1. On April 14, 2026, at 11:08 a.m., clinical nurse supervisor (CNS)-D acknowledged they did not have the evidence of screening for active TB with either a two-step TST or blood test and stated, "If TB testing if they had a positive then I believe with the state they need to show an x-ray and that is valid for I believe two years, I didn't realize we needed to have the positive as well." The licensee's Tuberculosis Screening/Prevention policy, dated January 15, 2026, indicated, the licensee would keep written documentation on file of the initial diagnosis of latent tuberculosis infection (LTBI) or active TB disease and the chest x-ray indicating no active TB disease that is dated after the date of the initial diagnosis of LTBI or active TB disease. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 660		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the	0 775		

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0 775	Continued From page 7 State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated April 14, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. 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	0 780		

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0 780	Continued From page 8 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 by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic	0 780		

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0 780	Continued From page 9 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, Physical Environment Inspection Report (PEIR) dated April 14, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 800 SS=C	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, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. 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)	0 800		

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0 800	Continued From page 10 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 the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated April 14, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and	01500		

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01500	Continued From page 11 reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure all employees that performed direct services completed all required	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41330	A. BUILDING: _____ B. WING _____	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDEN HEALTH CARE LLC	219 106TH AVE NW COON RAPIDS, MN 55448

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01500	Continued From page 12 training components for each twelve months of employment for one of three employees (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-B had a hire date of February 27, 2025, and provided direct care services to residents. ULP-B's employee record lacked annual training for the following required annual training topics: - reporting of maltreatment of vulnerable adults; - assisted living bill of rights; - infection control techniques; - effective approaches to use to problems solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; - review of provider policies and procedures; and - the principles of person-centered planning and service delivery. On April 14, 2026, at 11:32 a.m., licensed assisted living director (LALD)-C stated, "I will be honest he is my son, and I don't think he has completed those trainings. But it is something we are working on." The licensee's Orientation and Education policy,	01500		

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01500	Continued From page 13 dated January 15, 2026, indicated, all staff providing assisted living services will complete at least eight (8) hours of education for every twelve (12) months of employment, and the training would include the above-mentioned items. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
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	01530		

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01530	Continued From page 14 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 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 staff completed the required amount of dementia, mental illness and de-escalation training, in the required time frame for one of three employees (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-B had a hire date of February 27, 2025, and provided direct care services to residents.	01530		

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01530	Continued From page 15 ULP-B's employee record lacked annual training for the following required annual training topics: - Dementia Training: two (2) hours annually - Mental Illness and De-escalation Training: one (1) hour annually On April 14, 2026, at 11:32 a.m., licensed assisted living director (LALD)-C stated, "I will be honest he is my son, and I don't think he has completed those trainings. But it is something we are working on." The licensee's Orientation and Education policy, dated January 15, 2026, indicated, all staff providing assisted living services would complete at least two hours of dementia education for every twelve (12) months of employment. The licensee's Education on Mental Illness and De-escalation policy, dated January 15, 2026, indicated, direct care employees will complete at least one (1) hour of education on topics related to mental illness with de-escalation for each twelve (12) months of employment thereafter. 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	01620		

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01620	Continued From page 16 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 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	01620		

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01620	Continued From page 17 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 interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing nursing assessments not to exceed every 90-days for one of one residents (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 a large portion or all of the residents) The findings include: R1 was admitted to the licensee, and began receiving assisted living services on February 28, 2025. R1's record included a [Lisensee] Assisted Living Contract. signed by R1 on February 28, 2025. R1's diagnoses included hypertension. R1's Service Plan signed February 28, 2025, indicated R1 received assistance with dressing, grooming, bathing housekeeping, laundry, medication administration, and daily blood pressure monitoring. R1's record included 90-day ongoing	01620		

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01620	Continued From page 18 comprehensive assessments dated November 25, 2025, and March 6, 2026, indicating 101 days passed between R1's assessments. On April 13, 2026, at 12:30 p.m., clinical nurse supervisor (CNS)-D stated, "There is a note on top of the assessment explaining that it was late because we were going to be switching from paper to electronic documentation, I was here weekly and he had no change but I am letting you know, we are aware the assessment was late and we know that it needs to be done early or before the 90 days so going forward we will get it done within the time frame." The licensee's Assessment and Reassessment policy, dated January 15, 2026, indicated, "Ongoing resident reassessments must be conducted by an RN and cannot exceed 90 days from the last date of assessment." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription 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	01890		

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01890	Continued From page 19 review, the licensee failed to ensure medications were stored according to manufacturer's instructions for one of 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 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 April 13, 2026, at 11:50 a.m., the licensee's kitchen refrigerator was observed with clinical nurse supervisor (CNS)-D. The refrigerator contained the following medications for R1: -Etanercept (Enbrel) 50 milligram/milliliter injection (used for arthritis). The licensee lacked a temperature log for refrigerator temperature. Recommendations for medications storage as follows: -store in the refrigerator (2° to 8° Celsius [36° to 46° Fahrenheit]). Do not freeze. On April 14, 2026, at 11:26 a.m., licensed assisted living director (LALD)-C stated, "I didn't take time digging for [refrigerator temperature log], but I am sure I have it somewhere, and if not we will start implementing that right away." The licensee's Storage/Control of Medications policy, dated January 15, 2026, indicated, "Medications requiring refrigeration are clearly	01890		

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01890	Continued From page 20 labeled and stored in an enclosed container or area separated from foods. Temperature is maintained at 35-40 degrees." 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

Eden Health Care LLC
219 - 106th Ave NW
Coon Rapids, MN 55448
Anoka County
Parcel:

Phone: 612-404-5110

License Info

License: HFID 41330

Risk:
License:
Expires on:
CFPM: MAHAMUD ABDULLAHI MAHAMED
CFPM #: 4015; Exp: 5/22/2028

Inspection Info

Report Number: F1029261122
Inspection Type: Full - Single
Date: 4/13/2026 Time: 12:02:08 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 4
Total Priority 2 Orders: 2
Total Priority 3 Orders: 6
Delivery:

New Order: 2-100 Supervision
2-102.11D,E,F,G,H,I *Priority Level: Priority 2 CFP#: 1*
MN Rule 4626.0030DEFGHI The person in charge must be able to demonstrate their knowledge to the inspector of the importance of the following food handling procedures to preventing foodborne disease: handwashing; avoiding cross contamination; avoiding hand contact with ready-to-eat foods; time and temperature requirements for safely refrigerating, hot holding, cooling, and reheating TCS food; hazards of eating raw or undercooked meat, poultry, eggs, and fish; food temperatures and cooking times required to safely cook TCS food including meat, poultry, eggs, and fish; foods identified as major food allergens and the symptoms of an allergic reaction; identification of critical control points in a food service operation and steps to be taken to ensure the points are controlled.
COMMENT: PIC/CFPM UNAWARE POULTRY COOKING TEMPERATURE OF 165F. SAFE COOKING TEMPERATURES REVIEWED. PIC INSTRUCTED TO ENSURE POULTRY AND OTHER RAW ANIMAL PROTEINS ARE COOKED TO SAFE TEMPERATURES PRIOR TO SERVICE.
Comply By: 4/13/2026 Originally Issued On: 4/13/2026

! **New Order: 3-100 Food Characteristics: unadulterated**
3-101.11 *Priority Level: Priority 1 CFP#: 13*
MN Rule 4626.0125 Remove all unsafe and adulterated foods from the premises.
COMMENT: DARK AND LIGHT SUBSTANCES ACCUMULATED ON SLICED DELI MEATS AND SLICED CHEESE DISCARDED BY PIC. PIC INSTRUCTED TO ENSURE FOODS ARE MONITORED FOR CONTAMINATION AND SPOILAGE.
Comply By: 4/13/2026 Originally Issued On: 4/13/2026

! **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: RAW UNPASTEURIZED SHELL EGGS ABOVE RTE ITEMS IN REFRIGERATOR. PIC INSTRUCTED TO STORE EGGS LOWER LEVEL THAN RTE ITEMS OR TO STORE IN CONTAINER WITH HIGH SIDE WALLS.
Comply By: 4/13/2026 Originally Issued On: 4/13/2026

New Order: 3-300C Protection from Contamination: equipment/utensils, consumers
3-304.14F *Priority Level: Priority 3 CFP#: 41*
MN Rule 4626.0285F Single-use disposable sanitizer wipes must be used according to US EPA approved manufacturer's label use instructions.
COMMENT: DISINFECTANT WIPES NOT INTENDED FOR FOOD CONTACT SURFACES IN USE. PIC INSTRUCTED TO DISCONTINUE USING WIPES IN FOOD SERVICE ON FOOD CONTACT SURFACES AND TO ONLY USE WIPES INTENDED FOR FOOD CONTACT SURFACES.
Comply By: 4/13/2026 Originally Issued On: 4/13/2026

New Order: 3-300C Protection from Contamination: equipment/utensils, consumers
3-307.11 *Priority Level: Priority 3 CFP#: 39*
MN Rule 4626.0337 Protect food from miscellaneous sources of contamination.
COMMENT: INJECTABLE MEDICATION IN CONTAINER IN FRIDGE. PIC INSTRUCTED TO REMOVE FROM FRIDGE WITH FOODS/BEVERAGES OR ENSURE THE HOLDING CONTAINER HAS LIQUID TIGHT SEAL.
Comply By: 4/13/2026 Originally Issued On: 4/13/2026

! **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: REFRIGERATOR DOOR NOT HOLDING ITEMS AT 41F OR LESS. TCS TEMPERATURE ABUSED ITEMS DISCARDED BY PIC. PIC INSTRUCTED TO ADJUST, REPAIR, OR REPLACE FRIDGE AND VERIFY SAFE HOLDING TEMPERATURES IN THE DOOR PRIOR TO PLACING ADDITIONAL TCS ITEMS WITHIN.
Comply By: 4/13/2026 Originally Issued On: 4/13/2026

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 BAGS OF DELI MEATS WITHOUT DATE MARKS. ITEMS KNOWN TO HAVE BEEN OPENED ON 4/8 AT THE EARLIEST. PIC INSTRUCTED TO DATE MARK ALL IDENTIFIED ITEMS AND TO DISCARD AFTER 7TH DAY IF NOT USED.
Comply By: 4/13/2026 Originally Issued On: 4/13/2026

! **New Order: 4-100 Equipment Construction Materials**
4-101.11A *Priority Level: Priority 1 CFP#: 47*
MN Rule 4626.0450A Remove all unsafe multi-use equipment, utensils, and food storage containers that impart color, odors or tastes to food.
COMMENT: NONSTICK COOKING VESSELS WITH NONSTICK MATERIAL MISSING/FLECKING OFF. PIC INSTRUCTED TO REMOVE FROM FOOD SERVICE.
Comply By: 4/13/2026 Originally Issued On: 4/13/2026

New Order: 4-100 Equipment Construction Materials
4-101.18 *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0493 Discontinue using cleaning aids or utensils that can scratch or scour the nonstick coating of pots, pans, griddles, cookie sheets, waffle makers and other cookware.
COMMENT: NONSTICK COOKING VESSELS WITH SCRATCHED AND SCOURED NONSTICK COATING. NONSTICK COATING MISSING IN AREAS OF COOKING VESSELS. PIC INSTRUCTED TO ONLY USE CLEANING AND PREPARATION UTENSILS ON NONSTICK SURFACES THAT WILL NOT SCRATCH/DEGRADE NONSTICK MATERIALS.
Comply By: 4/13/2026 Originally Issued On: 4/13/2026

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: PREPARED CHICKEN HELD BEYOND SAME-DAY SERVICE. PIC INSTRUCTED TO STOP HOLDING PREPARED TCS FOODS BEYOND SAME-DAY SERVICE IN RESIDENTIAL FRIDGE.
Comply By: 4/13/2026 Originally Issued On: 4/13/2026

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: FRIDGE NOT HOLDING SAFE TEMPERATURES THROUGHOUT. PIC INSTRUCTED TO ADJUST, REPAIR, OR REPLACE TO ENSURE SAFE COLD HOLDING TEMPERATURES.
Comply By: 4/17/2026 Originally Issued On: 4/13/2026

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control
6-501.11 *Priority Level: Priority 3 CFP#: 55*
MN Rule 4626.1515 Maintain the physical facilities in good repair.
COMMENT: PAINTING MISSING AND FLECKING OFF ON AREA OF CABINETS. LAMINATE COVERING ON CABINET SHELVES TATTERED IN AREAS. PIC INSTRUCTED TO REPAIR OR REPLACE.
Comply By: 5/1/2026 Originally Issued On: 4/13/2026

Food & Beverage General Comment

FOOD AND BEVERAGE INSPECTION OF ALF CONDUCTED AS PART OF HRD SURVEY. INSPECTION FINDINGS COMMUNICATED TO HRD SURVEYOR, TESA BROWN, BSN, RN, NURSING EVALUATOR, FOLLOWING INSPECTION.

ALF'S KITCHEN RESIDENTIAL IN NATURE: LAMINATE FLOOR, LAMINATE COUNTERS, WOOD/COMPOSITE WOOD DRAWERS AND CABINETRY, SMOOTH PAINTED WALLS AND CEILING.

ALF USES HIGH HEAT DISHWASHER TO SANITIZE EQUIPMENT AND UTENSILS AND THERMAL STICKERS TO VERIFY SANITIZING TEMPERATURES.

TOPICS REVIEWED WITH PIC: EMPLOYEE ILLNESS LOGGING, EXCLUSION, AND REPORTING REQUIREMENTS; SANITIZING; HYGIENE AND HANDWASHING; PROTECTION FROM CONTAMINATION; VOMIT/FECAL MATTER CLEANUP PROCEDURE; TEMPERATURE CONTROL; DATE MARKING.

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 F1029261122 from 4/13/2026

MAHAMUD ABDULLAHI MAHAMED
PERSON IN CHARGE - LALD

Trevor McCliment

Trevor McCliment,
Public Health Sanitarian 3
651-201-3957
trevor.mccliment@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

Eden Health Care LLC
Coon Rapids
County/Group: Anoka County

Inspection Info

Report Number: F1029261122
Inspection Type: Full
Date: 4/13/2026
Time: 12:02:08 PM

New Record: Product/Item/Unit: CREAM CHEESE**; Temperature Process:** Cold-Holding
Location: FRIDGE DOOR at 45 Degrees F.
Comment:
Violation Issued?: Yes

New Record: Product/Item/Unit: SHAKE**; Temperature Process:** Cold-Holding
Location: FRIDGE DOOR at 49 Degrees F.
Comment:
Violation Issued?: Yes

New Record: Product/Item/Unit: DELI MEAT**; Temperature Process:** Cold-Holding
Location: FRIDGE INTERIOR at 40 Degrees F.
Comment:
Violation Issued?: No

New Record: Product/Item/Unit: SOUR CREAM**; Temperature Process:** Cold-Holding
Location: FRIDGE INTERIOR 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

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Coon Rapids
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Inspection Info

Report Number: F1029261122
Inspection Type: Full
Date: 4/13/2026
Time: 12:02:08 PM

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

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL41330015	**Date:** 4/14/2026
Facility Name: Eden Health Care LLC	
Facility Address: 219 106th Ave NW, Coon Rapids, MN 55448	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]

2. Lighted matches, cigarettes, cigars or other burning object shall not be discarded in such a manner that could cause ignition of other combustible material. [Minn. Stat. 144G.45 subd. 2; MSFC 310.7]

   Comments: Cigarette butts were observed on the ground in front of the facility. All smoking materials such as cigarettes should be disposed of in approved receptacles. Improperly discarded cigarette butts should be removed, and the property should be maintained free of smoking materials on the ground which may pose a fire hazard.

3. Listed single and multiple-station smoke alarms complying with UL 217 shall be installed. [Minn. Stat. 144G.45 subd. 2; MSFC 907.2.10]

   Comments: Some of the smoke alarms installed in the facility are not properly listed to UL standard 217. Facility staff could not provide documentation of proper listing for these devices and a review of the user manual failed to illustrate the required UL 217 certification to ensure smoke alarm durability and operability in an emergency situation. All smoke alarms should be properly listed to UL 217.

☒ **TAG IDENTIFICATION: 0780**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

1. Smoke alarms shall be interconnected so that actuation of one alarm causes all alarms in the individual dwelling or sleeping unit to operate where more than one smoke alarm is required within an individual dwelling or sleeping unit. [Minn. Stat. 144G.45 subd.2]

   Comments: Smoke alarms were not properly interconnected such that the activation of any alarm would cause all other alarms to sound. Several partial systems were present throughout the facility, but the alarms were not all interconnected together. All smoke alarms throughout the facility should be interconnected and maintained in proper working order.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 1; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

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1. The physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment are 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. [Minn. Stat. 144G.45 subd.2]

   Comments:

   The smoke alarm in the laundry room was installed in the middle of the wall, several feet from the ceiling. Smoke alarms should be installed and maintained within 12 inches of the ceiling to properly function and provide early detection of smoke.

   The exterior window trim on several windows was rotted and degrading. Window trim should be repaired and maintained in proper condition.

   The basement bathroom ceiling showed evidence of water damaged and warped ceiling panels. The bathroom ceiling should be repaired and maintained in proper condition free of water leak.

   The bathroom ventilation fan cover was visibly dirty and covered in dust. The vent fan should be cleaned and maintained free of accumulated dust that could gum up the vent fan.