Electronically Delivered

June 9, 2026

Licensee
Heritage Apartments Inc
1440 Midway Parkway
Saint Paul, MN 55108

RE: Project Number SL20280016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 7, 2026, 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 - 0775 - 144g.45 Subd. 2. (a) - 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

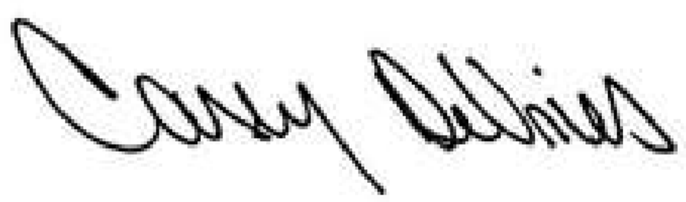
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms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



Casey DeVries, Supervisor
State Evaluation Team
Email: Casey.DeVries@state.mn.us
Telephone: 651-201-5917 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
	20280	A. BUILDING: _____ B. WING _____	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE APARTMENTS INC	1440 MIDWAY PARKWAY SAINT PAUL, MN 55108

(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: SL20280016-0 On May 4, 2026, through May 7, 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 were 62 residents; 22 receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 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 May 5, 2026, 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=D	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 that complied with accepted health care, medical, and nursing standards for infection control related to gloving and hand hygiene for one of three observed employees (unlicensed personnel (ULP)-G). 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).	0 510		

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0 510	Continued From page 4 The findings include: On May 5, 2026, from 8:25 a.m. to 9:33 a.m., while under continuous observation, the surveyor observed ULP-G assist residents with services. At 8:30 a.m., ULP-G completed hand hygiene at the medication cart and at 8:34 a.m., entered R4's room to assist R4 with the application of compression stockings. After completing the morning treatment, ULP-G exited R4's room and without completing hand hygiene entered R13's room and discussed morning treatments with R13. At 8:46 a.m., ULP-G left R13's room and without completing hand hygiene entered R9's room where ULP-G applied clean gloves and proceeded with applying lotion to R9's back. At 8:54 a.m., ULP-G removed the dirty gloves and documented services on their work-provided phone. At 8:56 a.m., ULP-G entered R10's room and, without completing hand hygiene, applied clean gloves and assisted R10 to apply compression stockings. At 8:59 a.m., ULP-G removed the dirty gloves and again documented services on their phone. At 9:01 a.m., ULP-G returned to the medication cart to retrieve a medication patch for R7. Without completing hand hygiene, at 9:03 a.m., ULP-G entered R7's room, applied clean gloves, and applied the patch to R7's lower back. At 9:05 a.m., ULP-G removed the dirty gloves and returned to the medication cart. At 9:13 a.m., ULP-G entered R11's room to obtain vital signs. At 9:14 a.m., without completing hand hygiene, ULP-G put on clean gloves. At 9:27 a.m., ULP-G removed the dirty gloves and at 9:29 a.m., ULP-G exited R11's room and the surveyor observed them enter an employee restroom. On May 5, 2026, at 2:33 p.m., director of nursing	0 510		

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0 510	Continued From page 5 (DON)-B stated staff were trained and expected to complete hand hygiene between glove changes. On May 5, 2026, at 2:35 p.m., ULP-G stated they were trained to complete hand hygiene in between glove changes but did not do so because they did not have hand sanitizer on their person to be used. The licensee's Hand Hygiene policy dated April 15, 2026, indicated the following: "Hand washing shall be performed between resident cares and whenever direct physical contact with a resident takes place. Use of gloves does not replace hand washing. Hands should be washed or decontaminated: a. Before and after direct contact with a resident b. If moving from a contaminated-body site to a clean-body site during resident care c. After contact with environmental surfaces or equipment in the immediate vicinity of the resident d. After removing gloves or gowns e. Before eating and after using a restroom" No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure,	0 650		

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0 650	Continued From page 6 registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records contained the required content for two of two staff (unlicensed personnel (ULP)-G, ULP-I). 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: ULP-G was hired May 2, 2024, to provide assisted living services.	0 650		

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0 650	Continued From page 7 ULP-G's record lacked documentation of annual performance reviews. ULP-I was hired January 5, 1987, and began providing assisted living services on August 1, 2021. ULP-I's record lacked documentation of annual performance reviews. On May 6, 2026, at 2:20 p.m., director of nursing (DON)-B stated that unlicensed personnel (ULP) annual performance reviews were out of date and had not been completed. The licensee's personnel records policy dated April 15, 2026, indicated personnel records would contain performance evaluations which identify areas of improvement needed and training needs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in	0 775		

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0 775	Continued From page 8 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 May 4, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under	01290		

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01290	Continued From page 9 this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was submitted and received in affiliation with the licensee's health facility identification number (HFID) for eight of eleven employees (unlicensed personnel (ULP)-K, ULP-L, ULP-M, ULP-N, ULP-O, ULP-P, ULP-Q, and registered nurse (RN)-R). 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: ULP-K ULP-K was hired August 13, 2024, to provide assisted living services. ULP-K's employee record contained a background study clearance for a facility under the same ownership umbrella as the licensee dated April 7, 2023, but lacked documentation to show a background study was affiliated to the licensee prior to the start of the survey. ULP-L ULP-L was hired July 8, 2025, to provide assisted	01290		

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01290	Continued From page 10 living services. ULP-L's employee record contained a background study clearance for a facility under the same ownership umbrella as the licensee dated July 10, 2025, but lacked documentation to show a background study was affiliated to the licensee prior to the start of the survey. ULP-M ULP-M was hired October 17, 2022, to provide assisted living services. ULP-M's employee record contained a background study clearance for a facility under the same ownership umbrella as the licensee dated October 14, 2022, but lacked documentation to show a background study was affiliated to the licensee prior to the start of the survey. ULP-N ULP-N was hired May 19, 2025, to provide assisted living services. ULP-N's employee record contained a background study clearance for a facility under the same ownership umbrella as the licensee dated May 19, 2025, but lacked documentation to show a background study was affiliated to the licensee prior to the start of the survey. ULP-O ULP-O was hired October 7, 2025, to provide assisted living services. ULP-O's employee record contained a background study clearance for a facility under the same ownership umbrella as the licensee dated October 6, 2025, but lacked documentation to show a background study was affiliated to the licensee prior to the start of the survey. ULP-P	01290		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01290	Continued From page 11 ULP-P was hired May 13, 2025, to provide assisted living services. ULP-P's employee record contained a background study clearance for a facility under the same ownership umbrella as the licensee dated May 8, 2025, but lacked documentation to show a background study was affiliated to the licensee prior to the start of the survey. ULP-Q ULP-Q was hired July 22, 2024, to provide assisted living services. ULP-Q's employee record contained a background study clearance for a facility under the same ownership umbrella as the licensee dated July 11, 2024, but lacked documentation to show a background study was affiliated to the licensee prior to the start of the survey. RN-R RN-R was hired January 14, 2025, to provide clinical oversite and assisted living services. RN-R's employee record contained a background study clearance for a facility under the same ownership umbrella as the licensee dated January 13, 2025, but lacked documentation to show a background study was affiliated to the licensee prior to the start of the survey. On May 6, 2026, at 11:34 a.m., human resources (HR)-C stated they had just affiliated the eight staff today. HR-C stated they understood it was a mistake and, in the future, would ensure that all staff were affiliated to the licensee. The licensee's Background Checks policy dated April 15, 2026, indicated employees as well as contractors, and regularly scheduled volunteers of the facility with direct resident contact will undergo a background study through DHS. Only	01290		

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	20280	A. BUILDING: _____ B. WING _____	05/07/2026

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01290	Continued From page 12 those with satisfactory results will continue to work with the facility and its residents. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01330 SS=D	144G.60 Subd. 4 (b) Unlicensed personnel (b) Unlicensed personnel performing delegated nursing tasks in an assisted living facility must: (1) have successfully completed training and demonstrated competency by successfully completing a written or oral test of the topics in section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform; (2) satisfy the current requirements of Medicare for training or competency of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or 484.36; or (3) have, before April 19, 1993, completed a training course for nursing assistants that was approved by the commissioner. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for one of two unlicensed personnel (unlicensed personnel (ULP)-G).	01330		

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01330	Continued From page 13 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-G was hired May 2, 2024, to provide assisted living services. On May 5, 2026, from 8:24 a.m. to 9:38 a.m., the surveyor observed ULP-G providing assisted living services to residents in an independent and unsupervised capacity. ULP-G's employee record lacked documentation of the completion of the following required training topics: - understanding appropriate boundaries between staff and residents and the resident's family; and - recognizing physical, emotional, cognitive, and developmental needs of the resident. On May 7, 2026, at 10:48 a.m., director of nursing (DON)-B stated the original training lists were created by nursing and then given to human resource (HR) personnel to distribute to staff, and staff were expected to complete all assigned trainings at the time of hire. DON-B stated HR was supposed to monitor employee records for compliance. On May 7, 2026, at 11:25 a.m., DON-B stated it was discovered after completing an audit that other staff had completed the trainings, and that	01330		

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01330	Continued From page 14 ULP-G's missing trainings must have been an oversite. The licensee's Assisted Living Orientation - ULP Staff policy dated April 15, 2026, indicated unlicensed personnel will receive orientation and training on topics required by Minnesota statutes and rules for assisted living organizations. The policy indicated the trainings would include appropriate boundaries between staff, residents, and resident families and recognizing physical, emotional, cognitive, and developmental needs of the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01330		
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	01500		

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01500	Continued From page 15 as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this 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:	01500		

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01500	Continued From page 16 Based on observation, interview, and record review, the licensee failed to ensure employees received at least eight (8) hours of annual training for each 12 months of employment for one of three employees (unlicensed personnel (ULP)-G)). 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-G was hired May 2, 2024, to provide assisted living services. On May 5, 2026, from 8:24 a.m. to 9:38 a.m., the surveyor observed ULP-G providing assisted living services to residents in an independent and unsupervised capacity. ULP-G's employee record lacked documentation for the completion of the following required annual training topic: - effective approaches to solve problems when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders. On May 6, 2026, at 10:48 a.m., director of nursing (DON)-B stated all training lists were created by nursing and then given to human resource (HR) personnel to distribute to staff. Staff were	01500		

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01500	Continued From page 17 expected to complete all assigned trainings. On May 7, 2026, at 11:25 a.m., DON-B stated it was discovered after completing an audit that other staff had completed the training, and that ULP-G's missing trainings must have been an oversite. The licensee's Assisted Living, Annual Training policy dated April 15, 2026, indicated staff will complete annual education to keep knowledge and skills current to provide quality care to residents. This annual training would include effective approaches for problem solving when working with challenging behaviors and effective approaches for communication with residents with dementia, Alzheimer's disease, or related disorders. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01530 SS=E	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	01530		

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01530	Continued From page 18 hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to 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 complete at least two hours of training on topics related to dementia for each 12 months of employment for two of three staff (unlicensed personnel (ULP)-G, ULP-I). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01530		

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01530	Continued From page 19 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: ULP-G ULP-G was hired May 2, 2024, to provide assisted living services. On May 5, 2026, from 8:24 a.m. to 9:38 a.m., the surveyor observed ULP-G providing assisted living services to residents in an independent and unsupervised capacity. ULP-G's record contained 1.75 hours of annual dementia care training completed February 11, 2025. The trainings were completed via Educare, an online training platform. ULP-G's record contained documentation of 0.75 hours of training in a course titled "Dementia - Activities - A Balanced Approach" and one hour of training in a course titled "Dementia - Overview - Overview". ULP-G's record contained two hours of mental illness and de-escalation training. ULP-I ULP-I was hired January 5, 1987, and began providing assisted living services August 1, 2021. ULP-I's employee record contained 1.75 hours of annual dementia care training. The trainings were completed via Educare. ULP-I's record contained documentation of 0.75 hours of training in a course titled "Dementia - Activities - A Balanced	01530		

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01530	Continued From page 20 Approach" completed on March 11, 2025, and one hour of training in a course titled "Dementia - Overview - Overview" completed on March 29, 2025. Additionally, ULP-I's record contained 1.25 hours of initial mental health training. The mental health training included 0.75 hours in a course titled "Mental Illness 2 - Bipolar, Anxiety, Psychosis and Trauma-Induced Disorders" and 0.5 hours in a course titled "Mental Illness 3 - Personality Disorders, Substance Abuse and De-escalation". On May 7, 2026, at 11:25 a.m., director of nursing (DON)-B stated they had initially assigned all staff to complete two classes of annual dementia training and erroneously assumed the two classes would cover the two required hours of dementia training. The licensee's Assisted Living Dementia, Mental Illness, and De-Escalation Training policy dated April 15, 2026, indicated direct care staff would complete a minimum of eight hours of initial training on dementia care topics and two hours of initial training on mental illness and de-escalation topics. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must	01640		

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01640	Continued From page 21 include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure each resident had a current service plan with a signature or other authentication by the resident to document agreement on the services to be provided for one of three residents (R3). 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:	01640		

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01640	Continued From page 22 R3 was admitted January 30, 2023, to receive assisted living services. R3's diagnoses included chronic obstructive pulmonary disease. R3's signed service plan dated March 19, 2024, indicated R3 received the following assisted living services: - nurse visits, PRN (as needed); - dining: setup, every day; - tray delivery, every day 9:00 a.m., 11:45 a.m., 5:15 p.m.; - trash removal, every day 9:00 a.m., 8:00 p.m.; - personal laundry: additional, PRN; - personal laundry - routine 1, every 2 weeks on Thursday 11:00 a.m.; - personal laundry - routine 2, every 2 weeks on Thursday 11: 45 a.m.; - personal laundry - routine 3, every 2 weeks on Thursday 12:45 p.m.; - inhaler 2x daily, every day 9:00 a.m., 8:00 p.m.; - medication: setup, every Tuesday; - topical 1x daily, PRN; - oral med (medication) 1-3x daily, 9:00 a.m., 8:00 p.m.; - breathing TX (treatment) 2x daily, 9:00 a.m., 8:00 p.m., and; - unscheduled HHA (home health aide) visit, PRN. R3's unsigned service plan dated May 5, 2026, indicated R3 received the following assisted living services: - nurse visits, PRN; - bathing: physical assist 1, every Tuesday and Friday; - dining: setup, every day; - tray delivery, every day; - monthly vital signs, every Wed;	01640		

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01640	Continued From page 23 - weight monitor, every 1st Wednesday; - trash removal, every day; - personal laundry: additional, every 2 weeks on Thursday; - linen laundry: routine-bed/tow, every 2 weeks on Wednesday at 11:30 a.m.; - linen laundry: routine-bed/tow, every 2 weeks on Wednesday at 9:00 a.m.; - personal laundry - routine 1, every 2 weeks on Thursday at 1:00 p.m.; - personal laundry - routine 2, every 2 weeks on Thursday at 1:30 p.m.; - personal laundry - routine 3, every 2 weeks on Thursday at 2:00 p.m.; - medication: setup, every Tuesday; - oral med 1-3x daily, 9:00 a.m., 8:00 p.m.; - O2 (oxygen) safety check, every day 12:00 a.m., 8:00 a.m., 1:00 p.m., 4:30 p.m., and 8:00 p.m.; - breathing TX 4x daily, every day 9:00 a.m., 1:00 p.m., 5:00 p.m., and 8:00 p.m., and; - O2 saturation monitor, every day 12:00 a.m., 8:00 a.m., 1:00 p.m., 4:30 p.m., and 8:00 p.m. R3's signed service plan dated March 19, 2024, indicated a total monthly cost of $2,149.83. R3's unsigned service dated May 5, 2026, indicated a total monthly cost of $4,550.00. The service plans indicated a monthly cost increase of $2,400.17, without documentation of agreement between the licensee and the resident or resident's representative on the services to be provided. On May 6, 2026, at 10:38 a.m., director of nursing (DON)-B stated the licensee had a change in cost in January and all service plans should have been updated and signed. DON-B stated the licensee did not issue an updated service plan for R3, and was not sure why that had not taken place. Additionally, DON-B stated they had office staff completing an audit on records to make sure	01640		

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01640	Continued From page 24 there was no widespread issue. The licensee's Contents of Service Plans policy dated April 15, 2026, indicated service plans and any revisions to services plans will have a signature or other authentication by the facility and by the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prescription medications were securely locked in a substantially constructed compartment and permitted only authorized personnel to have access. This had the potential to affect all residents in the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20280	A. BUILDING: _____ B. WING _____	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE APARTMENTS INC	1440 MIDWAY PARKWAY SAINT PAUL, MN 55108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01880	Continued From page 25 portion or all of the residents). The findings include: On May 5, 2026, at 7:46 a.m., the surveyor observed a multi-dose card of 25mg Sertraline tablets (a type of antidepressant commonly used to treat depression and anxiety disorders) on top of the licensee's unattended medication cart in a common area, near the dining room, on the main floor of the facility. On May 5, 2026, at 7:54 a.m., registered nurse (RN)-F stated they were assisting with medication adminstration that morning and the medication being left out was an oversite. RN-F stated all medication should be secured in the medication cart. The licensee's Storage of Medications policy dated April 15, 2026, indicated medications will be handled and stored by acceptable standards and when secured storage of medications is necessary, the RN will identify where the medications will be stored, how they will be secured or locked under proper temperature controls and who has access to the medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20280	A. BUILDING: _____ B. WING _____	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE APARTMENTS INC	1440 MIDWAY PARKWAY SAINT PAUL, MN 55108

(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 26 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 expired medications were disposed of. 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: R13 was admitted on January 31, 2023, to receive assisted living services. R13's diagnoses included interstitial pulmonary disease, acute kidney failure, and diastolic congestive heart failure. R13's service plan dated January 1, 2026, indicated R13 received assisted living services to include blood pressure monitoring, laundry, linen changes, and medication administration. R13's medication administration record for the month of May 2026 included the following medications: - acetaminophen 325 milligrams (mg), 2 tablets (650mg) by mouth every 6 hours as needed; and - benzonatate capsule 100mg (Tessalon perles),	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20280	A. BUILDING: _____ B. WING _____	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE APARTMENTS INC	1440 MIDWAY PARKWAY SAINT PAUL, MN 55108

(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 1 capsule by mouth three times daily as needed. R13's record included the following physician orders: - Start Tessalon Pearles 100mg three times daily as needed (PRN), dated February 17, 2025; - acetaminophen 325 mg tabs - 650mg - Take 650mg every 6 hours as needed for pain. Do not exceed 4000mg in a 24-hour period, dated May 14, 2024. On May 6, 2026, at 2:46 p.m., during an audit of the licensee's medication storage cart, the surveyor observed the following expired medications: - a card of acetaminophen 325g tablets with an expiration date of September 29, 2025, belonging to R13. - a card of benzonatate 100mg capsules with an expiration date of March 31, 2026, belonging to R13. On May 6, 2025, at 2:56 p.m., director of nursing (DON)-B stated the nurse was responsible for auditing the medication cart during cycle fills, and that included checking for expired medications. The licensee's Individualized Medication, Treatment & Therapy Management Plans policy dated April 15, 2026, indicated the registered nurse will develop a medication management plan for each resident receiving medication management services. The medication management plan will include a description of medication storage based upon the resident's needs, preferences, risk of diversion, and in keeping with the manufacturer's instructions. The plan would also include identification of people responsible for monitoring and ensuring timely refills of medications.	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20280	A. BUILDING: _____ B. WING _____	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE APARTMENTS INC	1440 MIDWAY PARKWAY SAINT PAUL, MN 55108

(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 28 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

The Heritage at Lyngblomsten
1440 MIDWAY PARKWAY
St Paul, MN 55108
Ramsey County
Parcel:

Phone:

License Info

License: HFID 20280

Risk:
License:
Expires on:
CFPM: Ernesto L. Figuera-Rojas
CFPM #: 6889; Exp: 11/10/2028

Inspection Info

Report Number: F1021261135
Inspection Type: Full - Single
Date: 5/5/2026 Time: 12:10:25 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 1
Total Priority 2 Orders: 2
Total Priority 3 Orders: 1
Delivery: Emailed

New Order: 3-300C Protection from Contamination: equipment/utensils, consumers
3-304.14D *Priority Level: Priority 3 CFP#: 41*
MN Rule 4626.0285D Provide an approved sanitizing solution for storage of the wet wiping cloths that is free of food debris and visible soil.
COMMENT: A WET WIPING CLOTH WAS OBSERVED STORED IN A SOAP AND WATER BUCKET AT THE FRONT COUNTER. DISCUSSED WITH THE DIRECTOR AND STAFF THAT ONCE WET, WIPING CLOTHS MUST BE STORED IN AN APPROVED SANITIZER SOLUTION. STAFF CORRECTED THE ISSUE DURING THE INSPECTION BY REMOVING THE CLOTH FROM THE SOAP AND WATER BUCKET. CORRECTED ON-SITE.
Comply By: Complied On Site Originally Issued On: 5/5/2026

New Order: 4-300 Equipment Numbers and Capacities
4-302.13B *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.
COMMENT: ESTABLISHMENT DOES NOT HAVE A MEASURING DEVICE THAT INDICATES THE FINAL UTENSIL SURFACE TEMPERATURE IN DISH MACHINE. PROVIDE.
Comply By: 5/12/2026 Originally Issued On: 5/5/2026

New Order: 4-300 Equipment Numbers and Capacities
4-302.14 *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.
COMMENT: QUATERNARY AMMONIUM (QUAT) TEST KIT ON-SITE WAS OBSERVED TO BE DISCOLORED, POSSIBLY DUE TO WATER DAMAGE OR AGE. STAFF WILL OBTAIN A NEW TEST KIT FOR THE THREE COMPARTMENT SINK DISPENSER.
Comply By: 5/12/2026 Originally Issued On: 5/5/2026

! **New Order: 4-700 Sanitizing Equipment and Utensils**
4-703.11B *Priority Level: Priority 1 CFP#: 16*
MN Rule 4626.0905B Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.
COMMENT: FINAL UTENSIL TEMPERATURE AT THE DISH MACHINE REACHED ONLY 154F DURING INSPECTION. STAFF MAY CONTINUE TO WASH ITEMS IN THE DISH MACHINE HOWEVER ALL DISHES AND UTENSILS MUST BE MANUALLY SANITIZED IN AN APPROVED SANITIZING SOLUTION IN THE THREE COMPARTMENT SINK UNTIL THE DISH MACHINE IS REPAIRED AND IS ABLE TO REACH A FINAL UTENSIL SURFACE TEMPERATURE OF AT LEAST 160F OR HIGHER.
Comply By: 5/5/2026 Originally Issued On: 5/5/2026

Food & Beverage General Comment

All findings on this report were discussed with Director of Culinary Services Laura Ericksen, Executive Director Cosmina Strain and Health Regulation Division Nurse Evaluator, Zachary Morth.

All hot food is prepared in the care center kitchen and transported to this kitchen. Food is intended for same day service, and any leftovers are taken back to the main kitchen at the end of service. No food preparation or cooking takes place in this kitchen.

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 F1021261135 from 5/5/2026

Laura Ericksen
Director of Culinary Services

Melissa Ramos

Melissa Ramos,
Public Health Sanitarian 3
651-201-4495
melissa.ramos@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

The Heritage at Lyngblomsten
St Paul
County/Group: Ramsey County

Inspection Info

Report Number: F1021261135
Inspection Type: Full
Date: 5/5/2026
Time: 12:10:25 PM

Food Temperature: Product/Item/Unit: Rice **; Temperature Process:** Hot-Holding
Location: Hot Wells at 138 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Corn Coconut Chowder **; Temperature Process:** Hot-Holding
Location: Hot Wells at 176 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Enchiladas **; Temperature Process:** Hot-Holding
Location: Hot Wells at 136 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Milk **; Temperature Process:** Cold-Holding
Location: Continental Upright Cooler at 41 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Salad **; Temperature Process:** Cooling from Ambient
Location: Continental Upright Cooler at 44 Degrees F.
Comment: Cooling from ambient for less than 1 hour
Violation Issued?: No

Food Temperature: Product/Item/Unit: Milk **; Temperature Process:** Cold-Holding
Location: Walk-in Cooler at 38 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Hard Boiled Eggs **; Temperature Process:** Cold-Holding
Location: Walk-in Cooler at 37 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Yogurt **; Temperature Process:** Cold-Holding
Location: Walk-in Cooler at 37 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

The Heritage at Lyngblomsten
St Paul
County/Group: Ramsey County

Inspection Info

Report Number: F1021261135
Inspection Type: Full
Date: 5/5/2026
Time: 12:10:25 PM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Dishwashing Area **Equal To** 154 Degrees F.
Comment: All dishes and utensils will be manually sanitized in the three compartment sink.
Violation Issued?: Yes

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** Wiping Cloth Bucket
Location: Front Counter **Equal To** 200 PPM
Comment:
Violation Issued?: No

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** 3-Compartment Sink
Location: Dishwashing Area **Equal To** 400 PPM
Comment:
Violation Issued?: No

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL20280016	**Date:** 5/4/2026
Facility Name: Heritage at Lyngblomsten -	
Facility Address: 1440 Midway Parkway, St. Paul, MN 55108	

☒ **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. Fire detection and alarm systems, emergency alarm systems, gas detection systems, fire-extinguishing systems, mechanical smoke exhaust systems and smoke and heat vents shall be maintained in an operative condition at all times and shall be replaced or repaired where defective. [Minn. Stat. 144G.45 subd. 2; MSFC 901.6]

   Comments:

   The annual fire alarm system report identified 6 detector heads that were not functioning properly. These detectors should be repaired or replaced, and all fire safety components should be maintained in proper working condition. The heat detector heads in the basement trash chute room were visibly deteriorated and degraded.

   The fire door leading to the third-floor elevator lobby was damaged. Fire-rated doors should be maintained in proper condition.

3. Single- and multiple-station smoke alarms shall be replaced when they fail to respond to operability tests or exceed ten years from the date of manufacture. Smoke alarms shall be replaced with smoke alarms having the same type of power supply. [Minn. Stat. 144G.45 subd. 2; MSFC 1103.8.1]

   Comments: The hardwired smoke alarms installed in resident rooms throughout the building were all past 10 years from date of manufacture in resident rooms. The hardwired smoke alarms indicated they were manufactured in 1994. Hardwired alarms that exceed 10 years of age should be replaced with newer hardwired smoke alarms and maintained in working condition. The power supply of hardwired

smoke alarms must be maintained. All provided alarms within the apartment units should interconnect such that when one is activated, all alarms within that unit sound.

4. Multiplug adapters, such as cube adapters, unfused plug strips or any other device not complying with NFPA 70 shall be prohibited. [Minn. Stat. 144G.45 subd. 2; MSFC 604.4]

   Comments: Unapproved multiplug adapters were in use in resident room 212, resident room 304, and resident room 316. Unapproved multiplug adapters should be removed.