



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

June 3, 2026

Licensee
Horizon Care LLC
1075 Rome Drive
Apple Valley, MN 55124

RE: Project Number(s) SL35990016

Dear Licensee:

On May 28, 2026, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on April 15, 2026. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Jodi Johnson'.

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

KKM



Protecting, Maintaining and Improving the Health of All Minnesotans

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May 13, 2026

Licensee
Horizon Care LLC
1075 Rome Drive
Apple Valley, MN 55124

RE: Project Number(s) SL35990016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 15, 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.

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 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - \$1,000.00

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration or a hearing, but not both. If you wish to contest tags without fines in

Horizon Care LLC

May 13, 2026

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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,

A handwritten signature in black ink, appearing to read "Jodi Johnson", with a stylized flourish at the end.

Jodi Johnson, Supervisor

State Evaluation Team

Email: Jodi.Johnson@state.mn.us

Telephone: 507-344-2730 Fax: 1-866-890-9290

CLN

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35990	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/15/2026
NAME OF PROVIDER OR SUPPLIER HORIZON CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1075 ROME DRIVE APPLE VALLEY, MN 55124			
(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: SL35990016-0 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 were five residents; five receiving services under the Assisted Living Facility license. 1290: An immediate order was issued on April 14, 2026, at a level 3/Widespread (I). The licensee took immediate action; however, the scope and level remain at I.	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.		
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request	0 460			

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 460	Continued From page 1 assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week. This had the potential to affect all current residents. 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:	0 460			

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0 460	Continued From page 2 On April 13, 2026, at 12:24 p.m. during the entrance conference, owner (O)-A stated the licensee did not have a call light or pendant system the residents could use to summon staff. On April 13, 2026, at 1:22 p.m. during facility tour, the surveyor observed the facility was a two-story split-level home with an upper level and lower level. The surveyor also observed no pendants, call light system, or means to request assistance were available in the residents' rooms. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 460			
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake;	0 470			

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0 470	Continued From page 3 (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a written staffing plan that included an evaluation completed by a registered nurse at least twice a year. 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 licensee'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: The licensee held an assisted living license and was licensed for a capacity of five residents with a current census of five residents. During the entrance conference on April 13, 2026, at 12:24 p.m., a staffing plan was requested. Clinical nurse supervisor (CNS)-B stated the licensee developed and implemented a staffing plan for determining its staffing level that included an evaluation, to be conducted at least twice a	0 470			

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0 470	Continued From page 4 year, of the appropriateness of staffing levels in the facility. However, the licensee failed to provide documentation. The licensee's undated, Staffing & Scheduling policy indicated the clinical nurse supervisor will develop and implement a staffing plan that provides an adequate number of qualified direct-care staff to meet the residents' needs 24-hours a day, seven-days a week. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 470			
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 infection control program to comply with accepted health care, medical, and nursing standards for infection control for one of two	0 510			

Minnesota Department of Health

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0 510	Continued From page 5 unlicensed personnel (ULP-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On April 14, 2026, at 7:57 a.m., the surveyor observed ULP-C apply gloves, assist R2 with morning medications and removed their gloves. ULP-C did not perform hand hygiene before or after glove use. On April 14, 2026, at 8:12 a.m., the surveyor observed ULP-C apply gloves, assist R1 with morning medication and removed gloves. ULP-C did not perform hand hygiene before or after glove use. On April 15, 2026, at 1:06 p.m., clinical nurse supervisor (CNS)-B stated staff are expected to complete hand hygiene before and after glove use. CNS-B stated she would provide more education with staff on policy/procedure. The licensee's Gloves policy dated March 11, 2024, indicated procedure is to wash hands, apply gloves, remove contaminated material, remove gloves, and rewash hands. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	0 510			

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0 510	Continued From page 6 days	0 510			
0 630 SS=D	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 all the required content 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 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: R1 was admitted to the licensee on May 21,	0 630			

Minnesota Department of Health

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0 630	Continued From page 7 2022, and began receiving assisted living services. R1's diagnosis included cervicalgia (neck pain localized in the cervical spine region). R1's record included a vulnerability assessment of the resident's susceptibility to abuse by other individuals and assessment of the resident's susceptibility to abuse other vulnerable adults; however, R1's record lacked the specific measures to be taken to minimize the risk of abuse to other vulnerable adults and to minimize the risk by other individuals. On April 15, 2026, at 1:06 p.m., clinical nurse supervisor (CNS)-B stated missing the specific measures to be taken to be abused and to abuse others. The licensee's Individual Abuse Prevention Plan policy dated March 11, 2024, indicated the plan will 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. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			

Minnesota Department of Health

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0 660	Continued From page 8	0 660			
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 establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included documentation of a completed two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test, and annual TB training for one of one employees (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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	0 660			

Minnesota Department of Health

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0 660	Continued From page 9 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The facility's TB risk assessment was completed December 5, 2025, and was determined to be a low risk level. ULP-C began providing direct care services for the licensee on April 9, 2024. On April 14, 2026, at 7:57 a.m., the surveyor observed ULP-C administer R2's morning medications. ULP-C's employee record lacked evidence of completed TB testing upon hire and annual TB training. On April 13, 2026, at 2:20 p.m., owner (O)-A stated ULP-C's employee record lacked a completed two step TST, only one TST. O-A stated he did not know the employees needed a two step TST, he thought they only needed one. O-A stated ULP-C needed to complete the annual training for TB and that his employee record lacked completion as well. The licensee's undated, Tuberculosis Screening policy indicated upon hire all staff would be screened for TB symptoms and tested for TB with either a two-step Mantoux (skin test) or an IGRA laboratory blood test. The results of the TB test will be recorded and kept in the employee's medical file. Staff will be educated regarding TB at the time of hire rather than the annual regulation. The Minnesota Department of Health (MDH)	0 660			

Minnesota Department of Health

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0 660	Continued From page 10 guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, indicated an employee may begin working with residents after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must	0 680			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER HORIZON CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1075 ROME DRIVE APPLE VALLEY, MN 55124			
(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
0 680	Continued From page 11 make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. 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: The licensee's Emergency Preparedness Program (EPP) last reviewed August 23, 2025, lacked evidence of the following required content: - review/update annually; - annual EPP employee training; and - exercises to test the plan at least twice per year. On April 14, 2026, at 2:07 p.m., owner (O)-A stated the licensee's EPP needs review/updating, annual employee training, and complete the emergency prep testing at least twice a year and it was missed.	0 680			

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0 680	Continued From page 12 The licensee's Emergency Preparedness Plan - Appendix Z Compliance policy dated March 11, 2024, indicated the licensee's EPP will include all required elements of appendix Z. The plan will be in writing and reviewed annually. Key elements of the plan will include staff training and exercises/drills. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to	0 810			

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0 810	Continued From page 13 include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to 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 15 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One	0 810			

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0 810	Continued From page 14 (21) days.	0 810			
01290 SS=I	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 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 one of one unlicensed personnel (ULP-D) was current and eligible on NETStudy 2.0 to provide direct cares without supervision. This had the potential to affect all three residents residing in the assisted living facility and resulted in an immediate correction order on April 14, 2026. This practice resulted in a level three violation (a violation that harmed a client/resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems	01290			

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01290	Continued From page 15 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: ULP-D was hired on October 16, 2020, to provide direct cares to the licensee's residents. ULP-D's employee record lacked evidence of a clear background study as required. On April 13, 2026, at 11:50 a.m., owner (O)-A was not able find ULP-D's cleared background study through NETStudy in ULP-D's employee chart as required. At approximately 3:20 p.m., O-A provided the surveyor with a roster affiliation date of April 13, 2026, (after the survey had begun), with determination "in process" On April 14, 2026, at 10:32 a.m., O-A stated ULP-D was scheduled to work on April 8-11, 2026, and was not directly supervised. The licensee's undated, Background Study policy indicated the licensee will conduct a Minnesota Department of Human Services Background Study on all employees and volunteers and contractors. No employee may provide direct services and have independent direct contact with any residents until acceptable results of the background study have been received. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate On April 14, 2026, the licensee took immediate action; however, the scope and level remain at I.	01290			

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01500	Continued From page 16	01500			
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss.	01500			

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01500	Continued From page 17 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 observation, interview, and record review, the licensee failed to ensure one of one employee (unlicensed personnel (ULP)-C) completed all required annual training topics for each 12 months of employment. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-C began providing direct care services for	01500			

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01500	Continued From page 18 the licensee on April 9, 2024. On April 14, 2026, at 7:57 a.m., the surveyor observed ULP-C administer R2's morning medications. ULP-C's record lacked evidence that ULP-C had completed the following annual training in the last 12 months of employment: - Reporting maltreatment of vulnerable adults; - Infection control techniques; and - Principles of person-centered planning/service delivery. On April 13, 2026, at 4:10 p.m., owner (O)-A stated he was unaware ULP-C was missing annual training and staff should have had all the required training and competencies. The licensee's Annual Required Staff Training policy dated March 11, 2024, indicated the following training elements MUST be included every 12 months to all staff who performs direct care services: - Training on reporting of maltreatment of vulnerable adults under section 626.557 - Review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases - Principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.	01500			

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01500	Continued From page 19 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 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	01530			

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01530	Continued From page 20 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 one of one employee (unlicensed personnel (ULP)-C) received the required amount of mental illness and de-escalation training within the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The facility held an assisted living license. ULP-C began providing direct care services for the licensee on April 9, 2024. On April 14, 2026, at 7:57 a.m., the surveyor observed ULP-C administer R2's morning medications.	01530			

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01530	Continued From page 21 ULP-C's employee record lacked documentation of the following training required: - at least two hours completed training in mental illness or de-escalation by July 1, 2025. On April 13, 2026, at 4:10 p.m., owner (O)-A stated the required training had not been completed by ULP-C. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency;	01650			

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01650	Continued From page 22 and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included the required content 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: R1 was admitted to the licensee on May 21, 2022, and began receiving assisted living services. R1's diagnosis included cervicalgia (neck pain localized in the cervical spine region). R1's service plan/care plan dated March 1, 2026, indicated R1 received services to include assistance with meals, medication administration, behavioral health monitoring, housekeeping, and laundry. On April 13, 2026, at 8:12 a.m., the surveyor	01650			

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01650	Continued From page 23 observed unlicensed personnel (ULP)-C administer R1's morning medication. R1's service plan lacked the following required content: - the frequency of each service; - the identification of the staff or categories of staff who will provide the services; - the schedule and methods of monitoring reviews or assessments of the resident; and - the schedule and methods of monitoring staff providing home care services. On April 14, 2026, at 12:04 p.m., owner (O)-A stated the service plan had not been developed to include the above required content, stating it was missed. O-A further stated all the current licensee's residents would be missing the same information as the licensee uses the same form. The licensee's undated, Service Plan policy indicated a service plan would include: - the frequency of each service; - the identification of the staff or categories of staff who will provide the services; - the schedule and methods of monitoring reviews or assessments of the resident; and - the schedule and methods of monitoring staff providing home care services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01650			
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in	01890			

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01890	Continued From page 24 the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were labeled correctly for three of three residents (R3, R2, 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 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: R3 R3 was admitted to the licensee on March 20, 2022, and began receiving assisted living services for a head injury. On April 14, 2026, at 7:24 a.m., the surveyor observed unlicensed personnel (ULP)-E administer R3's morning medication. During medication set up, the surveyor and ULP-E observed two unlabeled supplements: Hydroxycut and Ashlowagia. R2 R2 was admitted to the licensee on March 20,	01890			

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01890	Continued From page 25 2022, and began receiving assisted living services with obsessive compulsive disorder. On April 14, 2026, at 7:57 a.m., the surveyor observed ULP-C administer R2's morning medication. During medication set up, the surveyor and ULP-C a bottle of Acid controller and famotidine 10 milligrams (mg) with no label or prescription information. R1 R1 was admitted to the licensee on May 21, 2022, and began receiving assisted living services for cervicalgia (neck pain localized in the cervical spine region). R1's service plan dated March 1, 2026, indicated R1 received assistance with medication management. On April 14, 2026, at 8:12 a.m., the surveyor observed ULP-C administer R1's morning medication which included an unlabeled bottle of Florajen probiotic, 1 capsule daily and Flaxseed Oil 1200 mg. On April 14, 2026, at 9:13 a.m., clinical nurse supervisor (CNS)-B stated the medications the licensee stores should have a label on the bottle demonstrating ownership. The licensee's Medications - Prescription Drugs & Prohibition policy dated March 11, 2024, indicated a prescription drug 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. No further information was provided.	01890			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35990	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/15/2026
NAME OF PROVIDER OR SUPPLIER HORIZON CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1075 ROME DRIVE APPLE VALLEY, MN 55124			
(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 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

Page: 1

Establishment Info

Horizon Care LLC
1075 ROME DRIVE
Apple Valley, MN 55124
Dakota County
Parcel:

Phone:

License Info

License: HFID 35990

Risk:
License:
Expires on:
CFPM: Mohamed Noor
CFPM #: FM56232; Exp: 2/16/2028

Inspection Info

Report Number: F1004261110
Inspection Type: Full - Single
Date: 4/15/2026 Time: 11:30:00 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 2
Total Priority 3 Orders: 0
Delivery: Emailed

New Order: 4-300 Equipment Numbers and Capacities

4-302.12B Priority Level: Priority 2 CFP#: 36

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

COMMENT: NO SMALL-DIAMETER PROBE STYLE THERMOMETER ON SITE. PROVIDE AND MAINTAIN. *STAFF MEMBER WENT TO PURCHASE A SMALL-DIAMETER PROBE THERMOMETER DURING INSPECTION.

Comply By: 4/15/2026 Originally Issued On: 4/15/2026

New Order: 5-200C Plumbing: Maintenance, fixture location

5-205.11AB Priority Level: Priority 2 CFP#: 10

MN Rule 4626.1110AB The handwashing sink must be accessible at all times for employee use, and must be used only for handwashing.

COMMENT: DISHES FOUND STORED IN THE BASIN DESIGNATED FOR HANDWASHING. ENSURE THE BASIN DESIGNATED FOR HANDWASHING IS USED FOR HANDWASHING PURPOSES ONLY AND FULL ACCESS IS MAINTAINED AT ALL TIMES.

Comply By: 4/15/2026 Originally Issued On: 4/15/2026

Food & Beverage General Comment

INSPECTION WAS CONDUCTED BY MOLLY DOUGHERTY (FPLS) IN CONJUNCTION WITH A HEALTH REGULATIONS DIVISION (HRD) SURVEY CONDUCTED BY JENN PANITZKE.

DISCUSSED:

- EMPLOYEE ILLNESS POLICY AND LOG
- HANDWASHING
- PREVENTING BAREHAND CONTACT
- SANITIZER USE
- CLEANING/SANITIZING FOOD CONTACT SURFACES AND UTENSILS
- HIGH TEMPERATURE SANITIZING DISH MACHINE TEMPERATURE VERIFICATION
- DATE MARKING PROCEDURES
- THERMOMETER USE AND CALIBRATION
- SERVING A HIGHLY SUSCEPTIBLE POPULATION (NO RAW/UNDERCOOKED ANIMAL FOODS, NO UNPASTEURIZED JUICE, MILK, ETC)
- VOMIT/FECAL INCIDENT CLEAN UP PROCEDURES
- FOOD SOURCE
- RECEIVING DELIVERIES PROCEDURES

-
- FOOD SERVICE PROCEDURES (SAME-DAY SERVICE FOR ALL PREPARED FOODS)
 - PEST CONTROL
 - PHYSICAL FACILITIES AND MAINTENANCE

*REPORT WAS DISCUSSED WITH THE STAFF ON SITE AND WITH THE NURSE EVALUATOR AFTER THE INSPECTION HAD CONCLUDED.

*FLOORS ARE HARDWOOD, WALLS ARE SMOOTH PAINTED DRYWALL, AND CEILING IS "POPCORN" TEXTURE. COUNTERTOPS ARE SMOOTH SOLID STONE, AND CABINETS ARE VARNISHED WOOD WITH HALLOW BASE. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

*KITCHEN HAS A 2-BASIN SINK. ONE BASIN IS DESIGNATED AS THE HANDWASHING SINK. THIS BASIN MAY ONLY BE USED FOR HANDWASHING PURPOSES.

*KITCHEN HAS RESIDENTIAL GRADE EQUIPMENT. ALL FOOD MUST BE PREPARED AND SERVED SAME-DAY.

*IF ANY RESIDENT COMPLAINS OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE RESIDENT. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.

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 F1004261110 from 4/15/2026

Mohamed Noor
CFPM

Molly Dougherty

Molly Dougherty,
Public Health Sanitarian 3
651-201-3978
molly.dougherty@state.mn.us



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

Temperature Observations/Recordings

Page: 1

Establishment Info

Horizon Care LLC
Apple Valley
County/Group: Dakota County

Inspection Info

Report Number: F1004261110
Inspection Type: Full
Date: 4/15/2026
Time: 11:30:00 AM

Equipment Temperature: **Product/Item/Unit:** ambient temperature; **Temperature Process:** Cold-Holding

Location: Refrigerator at <40 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** cheese; **Temperature Process:** Cold-Holding

Location: Refrigerator at 41 Degrees F.

Comment:

Violation Issued?: No



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St Paul, MN 55164

Sanitizer Observations/Recordings

Page: 1

Establishment Info

Horizon Care LLC
Apple Valley
County/Group: Dakota County

Inspection Info

Report Number: F1004261110
Inspection Type: Full
Date: 4/15/2026
Time: 11:30:00 AM

Sanitizing Equipment: Product: Hot Water; **Sanitizing Process:** Dish Machine
Location: Kitchen **Equal To** 160 Degrees F.
Comment: *per operator's irreversible single-use temperature indicator
Violation Issued?: No

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL35990016-0	Date: 4/15/2026
Facility Name: Horizon Care LLC	
Facility Address: 1075 Rome Drive, Apple Valley, Mn 55124	

☒ TAG IDENTIFICATION: 0810

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Twenty One (21) days

1. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include employee actions to be taken in the event of a fire or similar emergency. [Minn. Stat. 144G.45 subd.2]

Comments: The FSEP did not contain any specific staff actions, only general evacuation information.

2. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include fire protection procedures necessary for residents. [Minn. Stat. 144G.45 subd.2]

Comments: The FSEP did not include any specific resident actions, only general evacuation information.

3. Employees of assisted living facilities shall receive training on the fire safety and evacuation plans (FSEP) upon hiring and at least twice per year thereafter. [Minn. Stat. 144G.45 subd.2]

Comments: Documentation of staff training was not able to be provided upon request.

4. Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. [Minn. Stat. 144G.45 subd.2]

Comments: Documentation of fire drills was not able to be provided for the 3rd shift.