Electronically Delivered

May 15, 2026

Licensee
Estherra Care LLC
4224 Winchester Lane
Brooklyn Center, MN 55429

RE: Project Number(s) SL39860016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 16, 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 - 1760 - 144g.71 Subd. 8 - Documentation Of Administration Of Medication - $1,000.00**

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

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

The correction order documentation should include the following:

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

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

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

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

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

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

a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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

CLN

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 39860 | A. BUILDING: _____ B. WING _____ | 04/16/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ESTHERRA CARE LLC | 4224 WINCHESTER LANE BROOKLYN CENTER, MN 55429 |

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| 0 000 | Initial Comments<br><br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.<br><br>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.<br><br>INITIAL COMMENTS:<br><br>SL42165016-0<br><br>On April 13, 2026, through April 16, 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: all of whom received services under the Assisted Living license.<br><br>An immediate correction order was identified on April 16, 2026, issued for SL39860016-0, tag identification 1760.<br><br>During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged. | 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 License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3. | |
| 0 480 SS=F | 144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services | 0 480 | | |

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| 0 480 | Continued From page 1<br><br>(a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626.<br>(b) For an assisted living facility with a licensed capacity of ten or fewer residents:<br>(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;<br>(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;<br>(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;<br>(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;<br>(5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, | 0 480 | | |

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| 0 480 | Continued From page 2<br><br>existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition;<br>(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<br>(7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code.<br><br>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).<br>The findings include:<br><br>Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated April 14, 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<br>TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates. | 0 480 | | |
| 0 550 SS=F | 144G.41 Subd. 7 Resident grievances; reporting maltreatment<br><br>All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to post the required information related to the grievance procedure and reporting contact information for the Office of Health Facility Complaints (OHFC).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic | 0 550 | | |

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| 0 550 | Continued From page 4<br>failure that has affected or has potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>On April 13, 2026, at 11:30 a.m., during the facility tour, the surveyor observed contact information for the Office of Ombudsman for Long Term Care (OOLTC), Office of Ombudsman for Mental Health and Developmental Disabilities (OMHDD), and Minnesota Adult Abuse Reporting Center (MAARC), posted on a bulletin board in the living room, on both sides of the licensee's duplex facility. The surveyor observed the licensee lacked the following postings:<br>- OHFC contact information.<br><br>On April 13, 2026, at 11:32 a.m., licensed assisted living director/registered nurse (LALD/RN)-D stated they were aware that they needed to post OHFC contact information, but it was overlooked.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 550 | | |
| 0 650 SS=F | 144G.42 Subd. 8 (a) Staff records<br><br>(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:<br>(1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; | 0 650 | | |

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| 0 650 | Continued From page 5<br><br>(2) records of orientation, required annual training and infection control training, and competency evaluations;<br>(3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision;<br>(4) documentation of annual performance reviews that identify areas of improvement needed and training needs;<br>(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<br>(6) documentation of the background study as required under section 144.057.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure employee records included all required content for three of six employees (unlicensed personnel (ULP)-A, ULP-F, registered nurse (RN)-E).<br><br>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).<br><br>The findings include:<br><br>ULP-A<br>ULP-A was hired on September 4, 2023, to provide direct care and services to residents. | 0 650 | | |

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| 0 650 | Continued From page 6<br><br>ULP-A's employee record included Assisted Living Staff Performance Review (144G Supervision Documentation) signed and dated February 26, 2024, and February 26, 2025.<br><br>ULP-A's employee record lacked an annual performance review completed in February 2026. ULP-A's employee record also lacked documentation to show ULP-A received unplanned times away medication preparation training.<br><br>ULP-F<br>ULP-F was hired on November 16, 2023, to provide direct care and services to residents. ULP-F's employee record lacked documentation to show ULP-F received unplanned times away medication preparation training.<br><br>RN-E<br>RN-E was hired on February 11, 2020, to provide oversight to the licensee's staff and to provide direct care services to the licensee's residents. RN-E's employee record included Annual Performance Review form signed and dated February 10, 2021, February 8, 2022, February 5, 2023, and February 10, 2024.<br><br>RN-E's employee record lacked an annual performance review completed in February 2025, and February 2026.<br><br>On April 14, 2026, at 11:54 a.m., licensed assisted living director/registered nurse (LALD/RN)-D stated they did train the ULPs mentioned above on unplanned times away medication preparation, but they did not have the documentation in the employee's record.<br><br>On April 15, 2026, at 10:47 a.m., ULP-F stated | 0 650 | | |

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| 0 650 | Continued From page 7<br><br>they were trained on how to do unplanned times away medication preparation by LALD/RN-D.<br><br>On April 15, 2026, at 1:17 p.m., LALD/RN-D stated they were aware they were missing annual performance reviews for all employees. LALD/RN-D stated they were working on getting things done and they did not expect the survey at this time.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 650 | | |
| 0 660 SS=F | 144G.42 Subd. 9 Tuberculosis prevention and control<br><br>(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.<br>(b) The facility must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) | 0 660 | | |

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| 0 660 | Continued From page 8<br><br>prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test, for one of five employees (unlicensed personnel (ULP)-A). In addition, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), to include an updated facility TB risk assessment. This had the potential to affect all residents, staff, and visitors.<br><br>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).<br><br>The findings include:<br><br>ULP-A was hired on September 4, 2023, to provide direct care and services to residents.<br><br>ULP-A's employee record included TB Screening and TB Risk Assessment completed on August 31, 2023, and a negative TB Exam result dated August 14, 2023. ULP-A's TB screening and TB risk assessment tool had a handwritten note, on the second page, read "[ULP-A], completed chest X-Ray due to previous positive skin test."<br><br>ULP-A's employee record lacked documentation of the TST or other evidence of TB screening such as a blood test. | 0 660 | | |

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| 0 660 | Continued From page 9<br><br>TB RISK ASSESSMENT<br><br>The licenseee's undated facility TB risk assessment was incomplete. The Incidence of TB section of the worksheet was completed with information from 2024, and the following sections of the worksheet were left blank:<br>- date worksheet was completed;<br>- worksheet completed by;<br>- TB training plan; and<br>- quality improvement.<br><br>On April 13, 2025, at approximately 2:00 p.m., licensed assisted living director/registered nurse (LALD/RN)-D stated the TB worksheet was not completed due to oversight.<br><br>On April 14, 2026, at 12:34 p.m., LALD/RN-D stated they were not aware employees needed a corresponding TST or TB blood test if they have chest x ray (CXR).<br><br>Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, indicated baseline TB screening is required for all health care workers.<br>Baseline TB screening consists of three components:<br>1. Assessing for current symptoms of active TB disease,<br>2. Assessing TB history, and<br>3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single TB blood test (IGRA).<br>An employee may begin working with patients after a negative TB symptom screen (i.e., no symptoms of active TB disease) and a negative IGRA or TST (i.e., first step) dated within 90 days | 0 660 | | |

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| 0 660 | Continued From page 10<br><br>before hire. The second TST may be performed after the HCW starts working with patients.<br><br>The Minnesota Department of Health Assisted Living Frequently Asked Questions for TB Screening last updated April 30, 2026, indicated a CXR alone is not acceptable documentation. Health care workers either need<br>- documentation of a positive two-step Tuberculin Skin Test (TST) or Interferon-Gamma Release Assay (IGRA) test, and<br>- a CXR with provider evaluation after that date<br>or<br>- documentation of refusal of both the two-step TST and IGRA<br>- followed by a new CXR and provider evaluation.<br>If the health care worker had a prior positive TB test result, and they only have the CXR but no other test documentation, then they need to take a new TB test. If the result is positive, a new CXR needs to be completed. The CXR needs to be done within 90 days of the positive test date or dated any time after the positive test date.<br><br>The Licensee's 8.16 Tuberculosis Screening Policy, dated June 1, 2021, indicated the licensee will 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 (MMWR). The policy also indicated that staff whose essential job functions require work within the same air space of home care clients will be screened and tested for tuberculosis prior to the staff being exposed to clients. Baseline (upon hire) screening will be completed, but serial | 0 660 | | |

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| | 39860 | A. BUILDING: _____ B. WING _____ | 04/16/2026 |

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| 0 660 | Continued From page 11<br><br>(annual) screening will only be required with increased occupational risk or exposure. Screening will be conducted as follows:<br>1. New staff will be screened for active signs of TB using the Baseline TB Screening Tool for HCWs.<br>2. New staff will have an IGRA blood test or a two-step Mantoux conducted with results documented on the Baseline TB Screening Tool for HCWs.<br>3. No staff will be permitted to begin work where the work involves sharing the air space with residents until the negative results of the first Mantoux are read and documented or a negative IGRA blood test result is received and documented.<br>4. Staff TB screening results will be kept in each employee medical file.<br>5. Staff should be screened for signs and symptoms on an annual basis.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 660 | | |
| 0 680 SS=F | 144G.42 Subd. 10 Disaster planning and emergency preparedness<br><br>(a) The facility must meet the following requirements:<br>(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;<br>(2) post an emergency disaster plan prominently;<br>(3) provide building emergency exit diagrams to | 0 680 | | |

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| 0 680 | Continued From page 12<br><br>all residents;<br>(4) post emergency exit diagrams on each floor; and<br>(5) have a written policy and procedure regarding missing residents.<br>(b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site.<br>(c) The facility must meet any additional requirements adopted in rule.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents under the assisted living license.<br><br>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).<br><br>The findings include:<br><br>The licensee's EPP last updated September 1, 2025, lacked evidence of the following required content:<br>- EPP program patient population; | 0 680 | | |

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| 0 680 | Continued From page 13<br><br>- development of EPP policies and procedures for:<br>- medical documentation;<br>- tracking of staff and residents during evacuation; and<br>- volunteer roles.<br><br>On April 15, 2026, at 11:55 a.m., licensed assisted living director/ registered nurse (LALD/RN)-D stated they used Appendix Z as guidance to develop the EPP. LALD/RN-D stated they must have left out some contents unknowingly. LALD/RN-D stated they had policies and procedures in the EPP book and stated they had it in our policy and procedure.<br><br>The licensee's undated Emergency Management policy read, "This plan uses the following terms to address an "all hazards" approach to all types of incidents. All-hazards planning is a sound and proven concept, but it does not mean that one must plan for every possible hazard. It does mean that one should consider all possible hazards as part of a risk analysis. Using a risk-based approach to planning, coupled with functional and prioritized contingency planning, makes the best possible use of limited resources."<br><br>Minnesota Administrative Rule 4659.0100 Emergency Disaster and Preparedness Plan dated August 11, 2021, indicated assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. The code references documents, specifications, methods, and standards in the State Operations Manual Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types. | 0 680 | | |

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| 0 680 | Continued From page 14<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 680 | | |
| 0 775 SS=E | 144G.45 Subd. 2. (a) Fire protection and physical environment<br><br>Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:<br><br>This MN Requirement is not met as evidenced by:<br>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.<br><br>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).<br><br>The findings include:<br><br>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. | 0 775 | | |

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| 0 775 | Continued From page 15<br><br>TIME PERIOD FOR CORRECTION: Two (2) days | 0 775 | | |
| 0 810 SS=F | 144G.45 Subd. 2 (b-f) Fire protection and physical environment<br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:<br>(1) location and number of resident sleeping rooms;<br>(2) staff actions to be taken in the event of a fire or similar emergency;<br>(3) fire protection procedures necessary for residents; and<br>(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.<br>(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.<br>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.<br>(e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year.<br>(f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. | 0 810 | | |

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| 0 810 | Continued From page 16<br><br>This MN Requirement is not met as evidenced by:<br>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.<br><br>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).<br><br>The findings include:<br><br>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.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 810 | | |
| 01530 SS=E | 144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De-<br><br>(a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements:<br>(1) supervisors of direct-care staff must have at least eight hours of initial training on dementia | 01530 | | |

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| 01530 | Continued From page 17<br>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;<br>(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;<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure two of six employees | 01530 | | |

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| 01530 | Continued From page 18<br><br>(unlicensed personnel (ULP-G), ULP-H) received at least eight hours of initial dementia care training within 160 working hours of their employment start date.<br><br>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).<br><br>The findings include:<br><br>ULP-G<br>ULP-G was hired on August 6, 2024, to provide direct care services to residents.<br><br>ULP-G's employee record included 7.75 hours of dementia training completed April 17, 2025, through December 20, 2025. ULP-G was 0.25 hours short of the required eight hours of dementia training within 160 working hours of their employment start date.<br><br>ULP-H<br>ULP-H was hired on November 4, 2025, to provide direct care services to residents.<br><br>ULP-H's employee record included 5 hours of dementia training completed October 24, 2025, through November 4, 2025. ULP-H was three hours short of the required eight hours of dementia training within 160 working hours of their employment start date. | 01530 | | |

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| 01530 | Continued From page 19<br><br>On April 14, 2026, at 12:35 p.m., licensed assisted living director/registered nurse (LALD/RN)-D stated the ULPs did not have the required eight hours of dementia training because the licensee did not assign all the required dementia training.<br><br>On April 15, 2026, at 2:00 p.m., LALD/RN-D stated all ULPs on the licensee's employee roster did provide direct care services to the licensee's residents and all of them had worked for the licensee for over 160 hours.<br><br>The licensee's 5.03 Dementia Training policy dated June 1, 2021, indicated direct care employees must have completed at least eight hours of initial training on required topics in 160 hours from employment. Until this training is complete, the employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training related to dementia care and who can act as a resource and assist if issues arise. A qualified trainer or a supervisor meeting the requirements must be available for consultation with the new employee until the training requirement is complete.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01530 | | |
| 01620 SS=D | 144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring<br><br>(a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. | 01620 | | |

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| 01620 | Continued From page 20<br>(b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery.<br>(c) Resident reassessment and monitoring must be conducted by a registered nurse:<br>(1) no more than 14 calendar days after initiation of services;<br>(2) as needed based on changes in the resident's needs; and<br>(3) at least every 90 calendar days.<br>(d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment.<br>(e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review.<br>(f) A facility must inform the prospective resident | 01620 | | |

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| 01620 | Continued From page 21<br><br>of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted a change of condition assessment in a timely manner using the uniform assessment tool for one of three residents (R2).<br><br>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).<br><br>The findings include:<br><br>R2 was admitted to the licensee on May 6, 2024, with diagnoses that included bipolar disorder, border line personality disorder, depression, anxiety, asthma, history of left femoral shaft fracture, cerebral vascular accident, hyperlipidemia, hypertension, polysubstance abuse, and venous insufficiency.<br><br>R2's Service Plan signed and dated May 31, 2024, indicated R2 received services for bathing, dressing, grooming, incontinence care, medication administration, manage symptoms, and manage behavior. | 01620 | | |

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| 01620 | Continued From page 22<br><br>R2's record included 90-day assessments completed on July 30, 2025, October 28, 2025, and January 26, 2026.<br><br>R2's record included an Orthopedic Surgery Operative Note signed and dated April 8, 2026. The note indicated R2 had same-day surgery for:<br>1) Removal of retained implants; left distal radius (volar plate and screws);<br>2) Left median nerve neurolysis;<br>3) Left carpal tunnel release;<br>4) Left wrist flexor tenolysis; and<br>5) Left flexor tendon lengthening (FDS [Flexor Digitorum Superficialis] long and ring fingers).<br><br>The note also had the following post-operative plan:<br>- Same day surgery, discharge once meets PACU (Post-Anesthetic Care Unit) criteria;<br>- NWB (non-weight bearing) RUE (right upper extremities) [SIC]for soft tissue rest in short arm splint;<br>- Encourage finger motion;<br>- Keep splint clean and dry;<br>- Tylenol, ibuprofen, oxycodone for pain control;<br>- Resume Aspirin otherwise no need for dvt ppx (deep vein thrombosis prophylaxis);<br>- Follow up in clinic on Monday April 13, 2026, with the provider for splint removal, wound check, and start hand therapy thereafter.<br><br>R2's record included a nurse's progress note written by RN-E entitled "Follow up surgery", dated April 10, 2026. The note read "The writer assessed the resident following return from surgery. Resident was alert and responsive during the visit. Examination of the left hand revealed circulation, movement, and sensation (CMS) intact. Dressing with ace wrap in place, | 01620 | | |

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| 01620 | Continued From page 23<br><br>clean, dry, and intact with no visible drainage noted. Left hand warm to touch with temperature within normal limits and comparable to the right hand. Capillary refill present and appropriate. Resident able to move fingers without difficulty and denied increased pain, numbness, or tingling at the time of assessment. No signs of acute distress observed. The writer will continue to monitor for any changes in neurovascular status, pain level, or signs of infection and report any concerns to the provider."<br><br>The progress note indicated RN-E conducted a focused assessment on R2's extremity two days after R2's surgical procedure. R2's record lacked a change of condition assessment using the uniform assessment tool upon R2's return from surgery to determine whether any changes of services were necessary.<br><br>R2's Notes from Care Team Orthopedic Clinic Office Visit dated April 13, 2026, indicated R2 presented to the clinic with the postop bandage having been disturbed. The note indicated the volar and the dorsal splinting which had been meticulously applied at the time of surgery was absent. There was old, dried blood on the 4 x 4's of the bandage, with no new bleeding noted. The note also read,<br>"Decision Making :<br>The patient was reassured that all appears to be healing satisfactorily. In addition, the splinting which was applied surgically was discussed with her, she was advised that this was put on for a specific reason. Premature removal allows for deformity of the wrist and fingers to redevelop, regardless of for how briefly. If time it is off [sic]. The patient opted to excuse that she removed it last night" because she knew it was coming off today anyway. Just she was advised that this is | 01620 | | |

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| 01620 | Continued From page 24<br><br>the material, that she may very well have compromise some of the results that was anticipated because of the premature removal of the splint.<br><br>The plan today is to have her seen by hand therapy fitted with a wrist cock up splint. She is to wear this on a near full-time basis while she continues working on active flexion and extension of her fingers. The need to be diligent in exercise frequently, that is for 5 to 7 minutes every hour in terms of stretching the finger flexors and working on active flexion of the fingers, was discussed and emphasized to her."<br><br>On April 15, 2025, at 1:10 p.m., clinical nurse supervisor (CNS)-C stated, "She had same day surgery and we did not do change of condition assessment and we were not sure if this was change of condition and also we were not sure if we were supposed to do assessment while the surveyor is on site as we were told it was not good to change things when the surveyor is on site".<br><br>The licensee's 6.01 Assessment, Reviews and Monitoring policy dated June 1, 2021, indicated resident reassessment, and monitoring must be conducted no more than 14 calendar days after initiating services. On-going reassessment and monitoring will be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last assessment.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01620 | | |

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| 01640 | Continued From page 25 | 01640 | | |
| 01640 SS=D | 144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to<br><br>(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.<br>(b) The service plan and any revisions must 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.<br>(c) The facility must implement and provide all services required by the current service plan.<br>(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.<br>(e) Staff providing services must be informed of the current written service plan.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure the current service plan included a signature or other authentication by the resident or resident's designated representative and the licensee to document agreement on the services to be provided for one of three residents (R3).<br><br>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 | 01640 | | |

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| 01640 | Continued From page 26<br><br>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).<br><br>The findings include:<br><br>R3 was admitted to the licensee on June 20, 2024, and started receiving assisted living services.<br><br>R3's diagnoses included traumatic brain injury (TBI) benign prostatic hyperplasia, bilateral dry eyes, cerebral hemorrhage, chronic kidney disease, depression, dysarthria, hyperlipidemia, hypertension, impaired lid closure (both eyes), non-aphasic cognitive communication deficits, peripheral artery disease, and severe oral dysphagia.<br><br>R3's unsigned Service Plan (waiver)- Addendum to Contract effective date April 15, 2026, indicated R3 received the following services: activity, bathing assistance- shower or bath, bedmaking, clinical monitoring, deep room cleaning, escort, eye patch, grooming, housekeeping, laundry, manage behavior, manage symptoms, medication administration, and safety check.<br><br>On April 15, 2026, at 12:35 p.m., registered nurse (RN)-E stated changes were made to R3's service plan and the current service plan was not signed because R3's guardianship expired, and R3's guardian did not want to be R3's guardian any longer and refused to sign. RN-E stated, "Right now he is his own person, and we just forgot to make him sign." | 01640 | | |

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| 01640 | Continued From page 27<br><br>The licensee's 6.08 Service Plan policy dated June 1, 2024, indicated the service plan and any revisions shall include a signature or other authentication by the licensee and by the resident, or resident's representative, documenting agreement on the services to be provided.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01640 | | |
| 01760 SS=G | 144G.71 Subd. 8 Documentation of administration of medication<br><br>Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure insulin was administered as prescribed and failed to document in the resident record when not administered as prescribed or any follow-up procedures that were provided to meet the | 01760 | | |

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| 01760 | Continued From page 28<br>resident's needs for one of two residents (R1).<br><br>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at 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).<br><br>The findings include:<br><br>R1 was admitted to the licensee on August 23, 2023, and began receiving assisted living services. R1's primary diagnosis was Insulin-Dependent Diabetes Mellitus (IDDM).<br><br>R1's Service Plan (Waiver)- Addendum to Contract signed August 23, 2023, indicated R1 received assistance with housekeeping, laundry, incontinence care, behavior management, symptom management, medication administration, and record blood glucose.<br><br>R1's signed physician order dated October 29, 2025, included the following orders for IDDM management:<br>- Ozempic (1milligram(mg)/dose) 4mg/3mliliter (ml) injection (Inj) inject 1mg subcutaneously (subq) once weekly on the same day every week;<br>- Novolag 70/30 flexpen Inj 60 units give 60 units with breakfast and dinner; and<br>- Lantus solostar 100u/ml Inj inject 25 units subq at bedtime.<br><br>R1's most recent assessment dated February 5, 2026, indicated the following information:<br>- Can correctly read aloud or verbalize instructions on medication container; | 01760 | | |

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| 01760 | Continued From page 29<br>- Can not verbalize what each medication is for and common side effects;<br>- Can not correctly state when medications are taken and proper dosage for each;<br>- Can correctly measure the appropriate amount of medication from container;<br>- Can correctly administer subcutaneous injections;<br>- In summary R1 requires set up and the presence of staff to take oral and injectable medications. He has a history of overdosing on insulin or not taking his medications when he manages them independently. His provider is aware of this behavior and continues to work with him to make adjustments.<br><br>R1's Individualized Medication Management Plan (IMMP) completed on February 5, 2026, indicated the following:<br>- Staff need to prep his insulin for him to take per the MAR. Resident can inject himself with the insulin pen or may also allow staff to give him subcutaneous injection of his insulin as well (whichever the resident prefers). He has been known to dose himself (provider aware);<br>- Staff to ensure medications are stored in the medication cabinet and locked when not in attendance; and<br>- Resident requires set up and the presence of staff to take oral and injectable medications. He has a history of overdosing on insulin or not taking his medications when he manages them independently.<br><br>On April 13, 2026, at approximately 12:00 p.m., the surveyor observed the licensee's medication storage cart; the surveyor did not observe any insulins pens for R1 in the medication cart.<br><br>R1's Medication Administration Record (MAR) for | 01760 | | |

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| 01760 | Continued From page 30<br><br>the month of April 2026, indicated the following orders for IDDM management:<br>- Ozempic (1milligram(mg)/dose) 4mg/3mliliter (ml) injection (Inj) inject 1mg subcutaneously (subq) once weekly on the same day every week;<br>- Novolag 70/30 flexpen Inj 60 units give 60 units with breakfast and dinner; and<br>- Lantus solostar 100u/ml Inj inject 25 units subq at bedtime.<br><br>R1's April 2026 MAR also indicated the following:<br>- R1 received Lantus 25 units at 8:15 p.m., on April 1, 6, and 9, 2026. The MAR indicated R1 declined Lantus on April 2, 3, 4, 5, 7, 8, 10-13, 2026.<br>- R1 received Novolog 70/30 60 units at 9:15 a.m., on April 1, 3, 4, 6, 7, 8, 9, 13 and 14. The MAR indicated R1 declined Novolog on April 2, 5,10, 11, and 12, 2026.<br>- R1 received Novolog 70/30 60 units at 5:15 p.m., on April 1, 4, 6, 7, 9, and 13. The MAR indicated R1 declined Novolog on April 2, 3, 5, 8, 10, 11, and 12, 2026.<br>- R1 received Ozempic 1mg at 8:15a.m., on April 9, and declined Ozempic on April 2, 2026.<br><br>The MAR did not indicate why R1 refused insulins and did not indicate if the nurse was informed about the refusal or any follow-up action taken.<br><br>On April 13, 2026, at 12:30 p.m., the surveyor inquired with registered nurse (RN)-E if they had any insulin supply for R1. RN-E replied yes and stated the insulins were stored in the refrigerator. The surveyor then asked if they stored opened insulin in the refrigerator as well. RN-E replied yes, and the surveyor observed RN-E unlock and open the refrigerator. RN-E asked unlicensed personnel (ULP)-A "where is the current insulin [for R1]?". ULP-A answered it was downstairs. | 01760 | | |

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| 01760 | Continued From page 31<br><br>The surveyor asked ULP-A where downstairs? ULP-A answered stating that R1 refused to give the insulin to ULP-A for storage and kept the insulin in their room; the surveyor followed ULP-A downstairs to R1's room. ULP-A knocked on R1's door, opened the door and asked R1, "where is your insulin?" R1 answered, "I used it up". ULP-A asked, "what?" R1 yelled, "I used it up this morning." ULP-A then walked out of the room and stated that they used it up this morning. ULP-A stated, "I was with him". The surveyor asked ULP-A if R1 normally kept the insulin in their room. ULP-A stated, "No, I brought it to him, I stood next to him until he takes it." The surveyor inquired why they did not know R1 had used up the insulin if they observed R1 administer it that morning and again asked ULP-A if they knew R1 kept the insulin in their room. ULP-A then stated, "yes he keeps it in his drawer". The surveyor asked if ULP-A had informed the RN that R1 keeps the insulin in their room. ULP-A stated yes, they informed the nurse.<br><br>On April 13, 2026, at 12:50 p.m., RN-E stated they had no knowledge R1 kept their insulin in their room. RN-E stated they did not know who gave the insulin pen to R1; RN-E stated, "resident said one of the staff gave it to him and I have to investigate."<br><br>On April 14, 2026, at approximately 9:20 a.m., R1 stated they wanted to do their own insulin but now the licensee took it away from them (during the survey). The surveyor asked R1 to explain how they self-administered their own insulin. R1 took out the blood sugar reader for a Libre sensor from their pocket and brought the reader close to the sensor which was on their right arm and showed a blood sugar reading of 316 to the surveyor. R1 then stated they took insulin when | 01760 | | |

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| 01760 | Continued From page 32<br><br>their blood sugar was high. The surveyor asked R1 if they were to take the insulin for a blood sugar of 316 what the dosage would be. R1 replied, "about 50 units". R1 also stated, "When the pen runs out, I come up here and the staff gives it to me. Then I keep it on top of my drawer." The surveyor asked how did you learned how to administer your own insulin. R1 stated the hospital nurses taught them how to do it.<br><br>On April 15, 2026, at approximately 1:00 p.m., the surveyor observed a new Novolog insulin pen labeled with R1's name and opened on date stored in the medication cart. The surveyor did not observe R1's Lantus.<br><br>On April 16, 2026, at 8:20 a.m., the surveyor checked the medication cart and did not observe R1's Lantus. The surveyor observed an unopened Lantus pen stored in the refrigerator. ULP-A stated R1 was not taking Lantus. R1 who was also present stated they were no longer taking Lantus, they stopped taking it about a year ago because Lantus made their blood sugar drop too low.<br><br>On April 16, 2026, at 8:44 a.m., via telephone, RN-E stated R1 sometimes still took the Lantus, but only when they wanted to. RN-E stated, "When he wants the Lantus we give it to him from the fridge we have informed the doctor and the resident's statement is not always 100% accurate."<br><br>On April 16, 2026, at 9:57 a.m., via telephone, pharmacist (P)-J stated R1 had an active order for Lantus and the last refill for Lantus was March 30, 2026.<br><br>On April 16, 2026, at 11:33 a.m., the surveyor | 01760 | | |

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| 01760 | Continued From page 33<br><br>referred RN-E to R1's IMMP where it said, "He has been known to dose himself (provider aware)" and asked RN-E to explain what that meant. RN-E stated R1 will not let the ULPs dose the medication for him, R1 would ask the ULPs to give him the pen, and he would dial the pen to whatever unit he wanted to give himself. RN-E stated they made the provider aware of the situation. RN-E stated they had documentation for contacting the doctor back in 2024, but they did not have any documentation to show that they communicated with the provider recently. The surveyor inquired if the ULPs had been documenting when the resident underdosed or overdosed on his insulin. RN-E stated the ULPs should be, but they had not been. RN-E also stated this was normal for R1 and the provider did not do anything about it.<br><br>R1's record included Resident Note written by RN-E on May 31, 2024, which read, "The writer faxed the current MAR and VSS for [provider name] to review. The resident is continued to noncompliance [sic] with taking correct dose for Novolog 70/30 at lunch and dinner. Left couple messages for [the providers name] office, still waiting to hear from them for further instruction. The resident has upcoming appt with [the providers name] on June 4th." The note did not mention R1's non-compliance with Lantus insulin.<br><br>R1's Resident Service Notes dated April 1, 2026, to April 16, 2026, included fifty-nine pages of status updates. The notes included multiple entries from ULPs stating R1 refused their medication, refused to check their blood sugar, and self-administered their insulin without checking their blood sugar. A ULP note written on April 1, 2026, at 7:00 a.m., read, "Resident will not allow staff to check his blood sugar during the | 01760 | | |

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| 01760 | Continued From page 34<br><br>shift, but he will check in absent of staff and call the figure to staff and administer his insulin without staff seeing the number of units taken by this client. Staff have conversation with him regarding checking B/S and insulin the risks and benefit staff having control of the insulin pen and checking his B/S but this client feel [sic] staff can't discuss anything about his prescriptions except his doctor or the facility nurse."<br><br>R1's two pages of Resident note- One Resident from April 1, 2026, to April 16, 2026, (written by nurses) did not include any follow up note regarding R1's insulin concerns mentioned in the ULPs notes, until April 16, 2026, (during the survey).<br><br>The licensee failed to ensure R1's record captured deviations R1 made to their insulin dosing during times of self-administration, reasons for medication refusals, or any follow-up actions taken to ensure R1's needs were met including correspondences to R1's physician of R1's on-going non-compliance.<br><br>The licensee's 7.08 Medication Management & Setup policy dated June 01, 2021, read "POLICY: The nursing staff and unlicensed personnel trained to provide medication administration at [the providers name] will document any medication administration provided accurately in each resident record. A licensed nurse will correctly and accurately document any medication setup provided.<br>PROCEDURE:<br>1. Documentation of a medication reminder, medication assistance or medication administration will be completed immediately after that task has been performed.<br>2. Medication reminders will be documented on | 01760 | | |

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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 |
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| 01760 | Continued From page 35<br>the medication administration record (MAR) by entering the unlicensed personnel (ULP) initials under "medication reminder'' and include the full signature and title of the person who provided the medication reminder.<br>3. Assistance with medication and medication administration will be documented on the MAR by entering the ULP's initials under the date and opposite the medication and dose given and include the full signature and title of the person who provided the medication administration.<br>4. For medication reminders or administration, the documentation must include the medication name, dosage, date and time administered, and method and route of administration.<br>5. For active assistance with medications from the dosage box system, the ULP will use the MAR for documenting medications given from a dosage box and will refer to the medications profile listing the medication name, dosage, date, and time· administered. It will also include the purpose of the medication and any special instructions if applicable.<br>6. The licensed nurse who sets up the medications in the dosage box will observe and monitor the past week's medication administration documentation and compliance and will initial that this has been done. The medication regimen will also be updated and reviewed at the same time of medication set up.<br>7. The licensed nurse who sets up the medications will also be observant of any problems regarding storage of medications.<br>8. A licensed nurse will set up medications in dosage boxes for the resident, usually on a weekly basis, and will make or direct changes between set ups when necessary. ULP will verify medications are set up correctly in the dosage box before administration to the resident by use of the medication profile. If any question of | 01760 | | |

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| 01760 | Continued From page 36<br><br>medication accuracy in the dosage box arises, the unlicensed staff will contact the licensed nurse and receive direct instructions on handling any necessary changes at that time, while in direct contact with the nurse.<br>9. ULP will chart in each resident's medication administration record any problems with medication administration, including refusals.<br>10. ULP will also document any reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan.<br>11. If initials are being used on a MAR, then a signature page must be used that includes the person's name, title, signature, and initials located in an accessible place as verification."<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Immediate<br><br>*ADDENDUM*<br><br>In addition, based on observation, interview, and record review, the licensee failed to ensure medication administration and effectiveness of as needed medication was documented for one of two residents (R2).<br><br>The findings include:<br><br>R2 was admitted to the licensee on May 6, 2024, with diagnoses that included bipolar disorder, border line personality disorder, depression, anxiety, asthma, history of left femoral shaft fracture, cerebral vascular accident, hyperlipidemia, hypertension, polysubstance | 01760 | | |

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| 01760 | Continued From page 37<br>abuse, and venous insufficiency.<br><br>R2's Service Plan signed and dated May 31, 2024, indicated R2 received services for bathing, dressing, grooming, incontinence care, medication administration, manage symptoms, and manage behavior.<br><br>R2's Medication Administration Record (MAR) for the month of April indicated the following for as needed medications:<br>- acetaminophen take one tablet by mouth four times a day (no strength or dosage in mg was mentioned in the order)<br>- ibuprofen 600mg tab take 1tab 600mg four times daily; and<br>- oxycodone take 1 tab 5mg every eight hours as needed for pain (started April 9, 2026).<br><br>The MAR indicated R2 had taken three tabs of oxycodone on April 9, 10, and April 13, 2026. Effectiveness of the oxycodone was charted April 10 and 13, 2026; the effectiveness of medication was not charted on April 9, 2026.<br><br>On April 15, 2026, at 1:30 p.m., RN-E provided the surveyor with empty bottle of oxycodone with R2's name and order label affixed to the bottle. The bottle indicated 12 tabs of Oxycodone were dispensed. RN-E stated the bottle was empty because R2 took Oxycodone around the clock. The surveyor then referred RN-E to the MAR and inquired why the MAR indicated only three tablets were given. RN-E then provided the surveyor with a handwritten narcotic record book which indicated 12 tablets of oxycodone were accounted for in the book from April 9, 2026, through April 13, 2026. RN-E stated they were not aware the ULPs did not chart oxycodone administration; they ULPs were trained to chart | 01760 | | |

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| 01760 | Continued From page 38<br><br>narcotic administration in the narcotic book as well as the computer system. RN-E stated they would identify the issue and follow up with disciplinary measures. RN-E stated the April 9 effectiveness of oxycodone was not charted as it was administered by RN-E and they had to leave for the day before it was time to chart effectiveness.<br><br>The licensee's 7.08 Medication Management & Setup policy dated June 1, 2021, indicated the nursing staff and unlicensed personnel trained to provide medication administration will document any medication administration provided accurately in each resident record. The policy included:<br>1. Documentation of a medication reminder, medication assistance or medication administration will be completed immediately after that task has been performed.<br>2. Assistance with medication and medication administration will be documented on the MAR by entering the ULP's initials under the date and opposite the medication and dose given and include the full signature and title of the person who provided the medication administration.<br>3. For medication reminders or administration, the documentation must include the medication name, dosage, date and time administered, and method and route of administration.<br>4. ULP will chart in each resident's medication administration record any problems with medication administration, including refusals.<br>5. ULP will also document any reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. | 01760 | | |

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| 01760 | Continued From page 39<br>6. If initials are being used on a MAR, then a signature page must be used that includes the person's name, title, signature, and initials located in an accessible place as verification.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01760 | | |
| 01820 SS=F | 144G.71 Subd. 13 Prescriptions<br><br>There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to maintain current medication orders for two of three residents (R1, R2).<br><br>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).<br><br>The findings include:<br><br>R1<br>R1 was admitted to the licensee on August 23, 2023, and began receiving assisted living | 01820 | | |

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| 01820 | Continued From page 40<br><br>services. R1's primary diagnosis was insulin-dependent diabetes mellitus (IDDM).<br><br>R1's Service Plan (Waiver)- Addendum to Contract signed August 23, 2023, indicated R1 received assistance with housekeeping, laundry, incontinence care, behavior management, symptom management, medication administration, and record blood glucose.<br><br>R1's Medication Administration Record (MAR) for the month of April 2026, indicated the following orders:<br>- Calcium antiacid 500 milligram(mg) chew and swallow one tablet by mouth twice a day;<br>- Lubricant eye drops place 1 drop into both eyes four times daily for dry eyes;<br>- Lidocaine patch 4% pad daily, apply to skin for 12 hours then remove for 12 hours. Apply on AM and take off at bedtime.<br><br>R1's signed physician orders dated October 29, 2025, did not include the above listed medications.<br><br>On April 15, 2026, at 2:08 p.m., registered nurse (RN)-E stated they did not have physician order for the above-mentioned medications; RN-E stated they would email the pharmacy and the providers to get them. The surveyor inquired how they entered the medications into the system for the unlicensed personnel to administer without a physician order. RN-E explained medication transcription procedure as follows: the licensee's preferred pharmacy gets the orders from the providers and they enter the medication orders into the system, then the system alerts the licensee's nurse to verify and schedule the medication before the medications could appear on resident's MAR for administration. The | 01820 | | |

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| 01820 | Continued From page 41<br><br>surveyor questioned how the nurse would verify when they did not have a physician order. RN-E stated they used the pharmacy labels from the medication bottles to approve and schedule the medication in the MAR.<br><br>R2<br>R2 was admitted to the licensee on May 6, 2024, with diagnoses that included bipolar disorder, border line personality disorder, depression, anxiety, asthma, history of left femoral shaft fracture, cerebral vascular accident, hyperlipidemia, hypertension, polysubstance abuse, and venous insufficiency.<br><br>R2's Service Plan signed and dated May 31, 2024, indicated R2 received services for bathing, dressing, grooming, incontinence care, medication administration, manage symptoms, and manage behavior.<br><br>R2's record included Orthopedic Surgery Operative Note signed and dated April 8, 2026. The note indicated the following written plan for R2's medication:<br>- Tylenol, ibuprofen, oxycodone for pain control; and<br>- Resume Aspirin otherwise no need for dvt ppx (deep vein thrombosis prophylaxis).<br><br>R2's Medication Administration Record (MAR) for the month of April indicated the following:<br>Scheduled Medication<br>- Aspirin 325 milligram (mg) was on hold from April 3, 2026, through April 15, 2026; and<br>- Ibuprofen 600mg tablet (tab) take 1 tab 600mg four times daily, (started on April 13, 2026).<br><br>As needed Medication | 01820 | | |

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| 01820 | Continued From page 42<br>- acetaminophen take one tablet by mouth four times a day (no strength or dosage in mg was mentioned in the order);<br>- ibuprofen 600mg tab take 1tab 600mg four times daily; and<br>- oxycodone take 1 tab 5mg every eight hours as needed for pain (started April 9, 2026).<br><br>On April 15, 2026, at 1:30 p.m., the surveyor referred registered nurse (RN)-E and clinical nurse supervisor (CNS)-C to R2's Tylenol, ibuprofen and oxycodone plan indicated on R2's Orthopedic Surgery Operative Note and inquired if R2 had been taking those medications. RN-E stated yes R2 was taking the medication. The surveyor then asked if R2 had a prescription for them. RN-E stated the Orthopedic Surgery Operative Note mentioned above was the order. RN-E stated they got the information as to how many milligrams to administer from the medication label on the bottle that R2 brought back after their surgery. RN-E then provided the surveyor with empty bottle of oxycodone with the following order label affixed to the bottle:<br>- oxycodone 5mg tab take 1 tab every eight hours as needed for pain. Quantity 12 tablets.<br><br>On April 16, 2026, at 8:16 a.m., via email, RN-E provided the surveyor with prescriptions they obtained during the survey for the following medications for R1:<br>- FT pain relief maximum strength 4% patch; and<br>- Tums 500mg oral chewable tablet.<br><br>On April 16, 2026, at 11:56 a.m., via email, RN-E provided the surveyor with a prescription they obtained during the survey for the following medication for R1:<br>- Lubricant eye drops PF 0.5 % ophthalmic | 01820 | | |

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| 01820 | Continued From page 43<br>solution.<br><br>The licensee did not have prescriptions nor did they obtain them during the survey for R2's pain medications.<br><br>The licensee's 7.02 Medication and Treatment Orders policy dated June 1, 2021, indicated a current, written prescriber's order must be obtained for any treatment or medication administration provided to a resident. The policy included:<br>1) The RN is responsible for assuring that:<br>a. current, authorized prescriber orders for medications or treatments administered by the staff are kept on file in the residents' records:<br>b. communicated to the resident or responsible party;<br>c. educate resident or responsible party on all medication and treatment orders, and<br>d. changes in orders are addressed in the resident's service plan and are communicated to the other staff.<br>2) An order for medication or treatment must contain the name of the resident, a description of the medication, treatment or therapy to be provided and the frequency, duration, and other information needed to carry out the order.<br>3) An order for medication or treatment must be dated, signed by the prescriber and must be current and consistent with the resident's nursing assessment.<br>4) Upon receiving verbal orders or unsigned electronic orders, a licensed nurse will record and sign the order and forward the written order to the prescriber for a signature after receipt of the verbal or electronic order. The licensed nurse will continue to follow-up with the prescriber's office until the signature is received.<br>5) The licensed nurse will communicate with the | 01820 | | |

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| 01820 | Continued From page 44<br><br>prescriber to ensure that the prescriber renews a medication or treatment/therapy order at least every 12 months, or more frequently as needed.<br>6) The licensed nurse will review all medication and treatment orders for progress, effectiveness and necessity on a regular basis and with resident change of condition.<br>7) The license nurse will also monitor and evaluate medication and treatment/therapy orders and services for effectiveness on a regular basis.<br>8) A resident's MAR and TAR will be audited regularly by licensed nurse or designee for documentation compliance.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01820 | | |
| 01890 SS=E | 144G.71 Subd. 20 Prescription drugs<br><br>A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to discard expired medication for two of five residents (R2, R3).<br><br>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 | 01890 | | |

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| 01890 | Continued From page 45<br><br>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).<br><br>The findings include:<br><br>On April 13, 2026, at approximately 12:10 p.m., the surveyor observed the following expired medication stored in the medication cart for R2 and R3:<br><br>R2<br>- clonidine 0.1 mg tablet, use by date February 3, 2025.<br><br>R3<br>- acetaminophen (Tylenol) 500 milligrams (mg), use by date November 13, 2024;<br>- nitroglycerin sublingual tablet 0.4mg tablet, use by date April 1, 2026; and<br>- fluticasone 50 micrograms (mcg), use by date February 8, 2025.<br><br>On April 13, 2026, at approximately 12:10 p.m., registered nurse (RN)-E stated they checked the medication cart every week for expired medications. RN-E stated the above-mentioned expired medications were overlooked.<br><br>The licensee's 7.08 Medication Management -Administration and Setup Policy dated June 1, 2021, indicated the licensed nurse who sets up the medications will also be observant of any problems regarding storage of medications.<br><br>No further information was provided. | 01890 | | |

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| 01890 | Continued From page 46<br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01890 | | |
| 01960 SS=D | 144G.72 Subd. 5 Documentation of administration of treatments<br><br>Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure treatments were transcribed and performed as ordered for one of three residents (R2).<br><br>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).<br><br>The findings include:<br><br>R2 was admitted to the licensee on May 6, 2024, with diagnoses that included bipolar disorder, | 01960 | | |

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| 01960 | Continued From page 47<br><br>border line personality disorder, depression, anxiety, asthma, history of left femoral shaft fracture, cerebral vascular accident, hyperlipidemia, hypertension, polysubstance abuse, and venous insufficiency.<br><br>R2's Service Plan signed and dated May 31, 2024, indicated R2 received services for bathing, dressing, grooming, incontinence care, medication administration, manage symptoms, and manage behavior.<br><br>R2's Orthopedic Surgery Operative Note signed and dated April 8, 2026, indicated the following plan after a same day surgery for their left upper extremity:<br>- Same day surgery, discharge once meets PACU (Post-Anesthetic Care Unit) criteria;<br>- NWB (non-weight bearing) RUE (right upper extremities) [SIC] for soft tissue rest in short arm splint;<br>- Encourage finger motion;<br>- Keep splint clean and dry;<br>- Tylenol, ibuprofen, oxycodone for pain control;<br>- Resume Aspirin otherwise no need for dvt ppx (deep vein thrombosis prophylaxis);<br>- Follow up in clinic on Monday April 13, 2026, with surgeon for splint removal, wound check, and start hand therapy thereafter.<br><br>R2's Orthopedic Clinic Office Visit note dated April 13, 2026, indicated R2 presented to the clinic with postop bandage having been disturbed. The volar and the dorsal splinting which had been meticulously applied at the time of surgery was absent. There was old dried blood on the 4 x 4's of the bandage, with no new bleeding noted. The note also read,<br>"Decision Making : | 01960 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 39860 | A. BUILDING: _____ B. WING _____ | 04/16/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ESTHERRA CARE LLC | 4224 WINCHESTER LANE BROOKLYN CENTER, MN 55429 |

| (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 |
|---|---|---|---|---|
| 01960 | Continued From page 48<br><br>The patient was reassured that all appears to be healing satisfactorily. In addition, the splinting which was applied surgically was discussed with her, she was advised that this was put on for a specific reason. Premature removal allows for deformity of the wrist and fingers to redevelop, regardless of for how briefly. If time it is off [sic]. The patient opted to excuse that she "removed it last night" because she knew it was coming off today anyway. Just [sic] she was advised that this is the material, that she may very well have compromise [sic] some of the results that was [sic] anticipated because of the premature removal of the splint.<br><br>The plan today is to have her seen by hand therapy fitted with a wrist cock up splint. She is to wear this on a near full-time basis while she continues working on active flexion and extension of her fingers. The need to be diligent in exercise frequently, that is for 5 to 7 minutes every hour in terms of stretching the finger flexors and working on active flexion of the fingers, was discussed and emphasized to her."<br><br>R2's service recap summary for April 2026, did not include the following post-surgery orders:<br>- NWB (non-weight bearing) RUE (right upper extremities) [SIC] for soft tissue rest in short arm splint;<br>- Near fulltime use of the cock up splint;<br>- Exercise frequently, that is for 5 to 7 minutes every hour in terms of stretching the finger flexors and working on active flexion of the fingers;<br>- Encourage finger motion; and<br>- Keep splint clean and dry.<br><br>On April 15, 2026, at 12:45 p.m., clinical nurse supervisor (CNS)-C stated R2 started wearing the hand brace (cockup splint) on Monday (April 13, | 01960 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 39860 | A. BUILDING: _____ B. WING _____ | 04/16/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ESTHERRA CARE LLC | 4224 WINCHESTER LANE BROOKLYN CENTER, MN 55429 |

| (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 |
|---|---|---|---|---|
| 01960 | Continued From page 49<br><br>2026). CNS-C stated they did not get the chance to add hand brace to the service order, service plan, or the individualized treatment and therapy plan and cited their participation in the survey for the reason.<br><br>On April 15, 2026, at 1:00 p.m., CNS-C stated the orders mentioned above should have been entered into their system. CNS-C also stated there were instructions for exercises, they were not entered into the system due to the survey.<br><br>The above-mentioned treatment orders were not transcribed into the licensee's electronic medical records system for the ULPs to perform the tasks nor was the resident assessed and deemed to be competent to independently perform the tasks.<br><br>The licensee's 7.05 Treatment and Therapy Management Plan policy dated June 1, 2021, indicated the licensee will develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following:<br>a. A statement of the type of services that will be provided<br>b. Documentation of specific resident instructions relating to the treatments or therapy administration<br>c. Identification of treatment or therapy tasks that will be delegated to unlicensed personnel<br>d. Procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services<br>e. Any resident-specific requirements relating to documentation of treatment and therapy received<br>f. Verification that all treatment and therapy was administered as prescribed<br>g. Monitoring of treatment or therapy to prevent | 01960 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 39860 | A. BUILDING: _____ B. WING _____ | 04/16/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ESTHERRA CARE LLC | 4224 WINCHESTER LANE BROOKLYN CENTER, MN 55429 |

| (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 |
|---|---|---|---|---|
| 01960 | Continued From page 50<br><br>possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01960 | | |

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

Estherra Care LLC
4224 Winchester Lane
Brooklyn Center, MN 55429
Hennepin County
Parcel:

Phone:

## License Info

License: HFID 39860

Risk:
License:
Expires on:
CFPM: Esther Wako
CFPM #: 14795; Exp: 12/6/2028

## Inspection Info

Report Number: F1043261123
Inspection Type: Full - Single
Date: 4/14/2026 Time: 2:52:54 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 1
Delivery:

**New Order: 2-100 Supervision**
2-102.12AMN *Priority Level: Priority 3 CFP#: 2*
*MN Rule 4626.0033A* Employ a certified food protection manager (CFPM) for the establishment.
COMMENT: TOTAL OF FIVE FACILITIES EXIST. PER STAFF, LISTED CFPM IS THE CFPM FOR A TOTAL OF 3 FACILITIES. ADVISED STAFF TO EMPLOY A FULL TIME EMPLOYEE TO COVER ADDITIONAL FACILITIES, CFPM MAY BE SHARED BETWEEN ONLY TWO FACILITIES. COMPLY WITH ABOVE RULE.
*Comply By: 4/14/2026 Originally Issued On: 4/14/2026*

# Food & Beverage General Comment

TEMPERATURE (F)
KITCHEN COOLER: MILK 44 (COOLING FROM AMBIENT), SAUSAGE 44 (COOLING FROM AMBIENT), DELI SLICES 41, DELI MEAT 40

UTENSIL SURFACE TEMPERATURE (F)
DISH MACHINE IS TESTED AT LEAST ONCE A WEEK BY FACILITY, TEST RESULT FROM 4/13 MEASURED AT LEAST 160F.

Inspection was completed with Dee Mosissa as the lead Health Regulation Division Nurse Evaluator completing the site survey.

Discussed highly susceptible populations, date marking, illness policy, sanitizer use, ware washing, temperature control, same day food service, cleaning, pest control, vomit/fecal procedures, test kits, food storage, and food handling procedures.

This facility has a residential kitchen with residential equipment, laminated cabinetry, tiled flooring, smooth walls, and smooth ceilings. Dish machine has a sani rinse option (Whirl Pool). Conditions of equipment and physical facility will be monitored during future inspections – must be brought up to code if at such time they are found to be a concern or risk of contamination.

Contact Health Regulation Division for plan review approval when facility/kitchen undergoes remodeling, major equipment additions, or changes of equipment due to a menu change.

***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.

***If any customer complains of illness, establishment is required to notify the Minnesota Department of Health and provide the foodborne illness hotline phone number to the customer: 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 F1043261123 from 4/14/2026**

Esther Wako
PIC

Blia Lor,
Public Health Sanitarian 1
651-355-0641
blia.lor@state.mn.us

# Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

| | |
|---|---|
| **Project No:** SL39860016-0 | **Date:** April 15, 2026 |
| **Facility Name:** Estherra Care LLC | |
| **Facility Address:** 4224 Winchester Lane, Brooklyn Center, MN 55429 | |

☒ **TAG IDENTIFICATION: 0775**

**SCOPE/ SEVERITY:** Level 2; Pattern **TIME PERIOD OF CORRECTION:** Two (2) 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. A means of egress shall be free from obstructions that would prevent its use. [Minn. Stat. 144G.45 subd. 2; MSFC 1031.3]

   *Comments: In occupied resident bedroom four, the cover installed on top of the window well prevented the egress window from opening. When covers are installed on window wells for egress windows, these covers must not interfere with the opening of the window in any way.*

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

   *Comments: Burnt cigarettes had been discarded in the yard and in the landscaping around the building. Additionally, burnt cigarettes had been disposed of inside a plastic container stored on top of a plywood table in the enclosed porch of the detached garage. Improper smoking material disposal creates a fire hazard.*

☒ **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 the location and number of resident rooms. [Minn. Stat. 144G.45 subd.2]

*Comments:*
*- The evacuation floor plans posted in the common areas did not include a number identifier for resident bedroom five.*
*- The fire safety and evacuation floor plans in the emergency operations binder did not include resident bedroom numbers.*
*The number identifiers installed at the resident bedroom doors need to correspond with the floor plans to provide efficient communication for exiting in the event of a fire or similar emergency.*

2. 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 fire safety and evacuation plan (FSEP) was not maintained with site specific employee actions to take in the event of a fire relative to the facility's building layout and environmental risks.*
   *Record review of the available documentation indicated the following:*
   *- Portable fire extinguisher locations were not accurate on the FSEP floor plans.*
   *- The FSEP Fire Emergency Response Standard Operating Procedure 2.06.4.1 was from a third party template and the employee actions were limited to the RACE (Remove, Alarm, Confine, Extinguish/Evacuate) and PASS (Pull, Aim, Squeeze, Sweep) acronyms. The plan inaccurately referenced pull fire alarms.*
   *Licensed assisted living director/registered nurse (LALD/RN)-D stated they were in the process of developing new FSEP procedures.*

3. 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 fire safety and evacuation plan failed to include site specific instructions for residents. LALD/RN-D stated they were in the process of developing new FSEP procedures.*

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

   *Comments: The fire safety and evacuation plan (FSEP) failed to include procedures for the individualized unique needs of residents. LALD/RN-D stated one of the current residents would require employee assistance in the event of an emergency evacuation and verified these procedures were not with the FSEP.*

5. 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: The surveyor requested records for evacuation drills completed between April 2025 and April 2026, from the licensee. Record review of the provided fire drill reports indicated drills were not conducted in May, June, July, October, or November 2025. Evacuation drills were not completed at a frequency of every other month.*