Electronically Delivered

February 27, 2026

Licensee
Immaculate Home Inc
29 Darlene Street
Saint Paul, MN 55119

RE: Project Number(s) SL38437017

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 4, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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

St - 0 - 0340 - 144g.30 Subd. 5 - Correction Orders - $500.00

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

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

The correction order documentation should include the following:

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

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

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

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

factor.

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

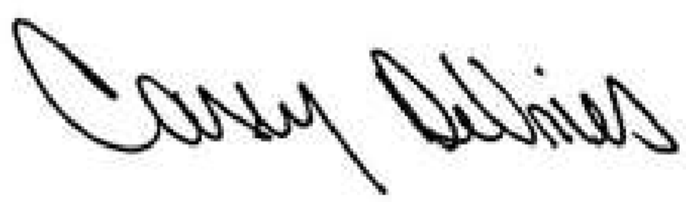
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms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

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

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

If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Email: Casey.DeVries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38437	A. BUILDING: _____ B. WING _____	02/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IMMACULATE HOME INC	29 DARLENE STREET SAINT PAUL, MN 55119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL38437017-0 On February 2, 2026, through February 4, 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 four residents; four receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level pursuant to 144G.31 Subd. 1, 2 and 3.	
0 340 SS=F	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or staff	0 340		

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0 340	Continued From page 1 of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must: (1) document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and execute a plan of correction (POC) for correction orders related to 144G.70 Subd. 2. (c-f) for initial reviews, assessments, and monitoring issued following their previous routine survey conducted January 21, 2025, through January 24, 2025. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all	0 340		

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0 340	Continued From page 2 of the residents). The findings include: The licensee received their correction orders via electronic delivery on March 3, 2025, following their January 21-24, 2025, survey. The longest period for correction on the correction orders from the date of receipt was 21-days. MN Statute 144G.30 Subd. 5 (c) (1) indicates by the correction order date; the facility must document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon complaint investigation, and as otherwise needed. On February 2-4, 2026, the Minnesota Department of Health (MDH) conducted a change of ownership survey and re-issued correction orders for resident initial reviews, assessments, and monitoring issued. On February 3, 2026, at 8:03 a.m., clinical nurse supervisor (CNS)-A stated they did not have any formal documentation of a plan of correction from their previous survey citations. CNS-A stated they just made the necessary changes. On February 3, 2026, at 11:01 a.m., CNS-A stated they wanted to use Residex (online charting software) to track when assessments were required to be completed for residents since their previous survey. CNS-A stated they were not sure how to setup the correct frequency in Residex and was still working on figuring it out. CNS-A stated it gets to be a lot trying to keep track of all of the resident assessments and when they were due to be completed. CNS-A stated	0 340		

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0 340	Continued From page 3 they needed to do better at getting assessments completed on time. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions;	0 470		

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0 470	Continued From page 4 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to evaluate or update their staffing plan at least twice annually. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: At the time of the survey, there were four residents; all four residents received assisted living services. The licensee's Staffing Plan was undated. The staffing plan indicated the licensee, "currently has 2 residents." The licensee had four residents living at the facility during the survey. On February 3, 2026, at 12:52 p.m., the surveyor inquired if they had a dated staffing plan to provide or documentation it had been reviewed or updated. Clinical nurse supervisor (CNS)-A stated, "Oh, are we supposed to update it? We just have the one we provided to you." CNS-A stated they had never reviewed or updated the staffing plan. The licensee's Staffing policy revised on April 24, 2023, indicated, "The staffing plan shall be evaluated as part of the Quality Management program at least twice per year. The results of the	0 470		

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0 470	Continued From page 5 evaluation are documented in the meeting minutes." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a	0 480		

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0 480	Continued From page 6 manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to	0 480		

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0 480	Continued From page 7 affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated February 2, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee on February 3, 2026. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 500 SS=F	144G.41 Subd. 2 Policies and procedures Each assisted living facility must have policies and procedures in place to address the following and keep them current: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (2) conducting and handling background studies on employees; (3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (4) handling complaints regarding staff or services provided by staff; (5) conducting initial evaluations of residents' needs and the providers' ability to provide those services; (6) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (7) orientation to and implementation of the	0 500		

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0 500	Continued From page 8 assisted living bill of rights; (8) infection control practices; (9) reminders for medications, treatments, or exercises, if provided; (10) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; (11) ensuring that nurses and licensed health professionals have current and valid licenses to practice; (12) medication and treatment management; (13) delegation of tasks by registered nurses or licensed health professionals; (14) supervision of registered nurses and licensed health professionals; and (15) supervision of unlicensed personnel performing delegated tasks. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement current policies and procedures as required. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee failed to provide the following policies and procedures related to current	0 500		

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0 500	Continued From page 9 assisted living assessment requirements under 144G.70 subdivision 2: - competency training and evaluations of staff; - conducting initial evaluations of residents' needs and the providers' ability to provide those services; - conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; - conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; and - medication and treatment management. On February 3, 2026, at 3:00 p.m., the surveyor emailed licensed assisted living director (LALD)-D and clinical nurse supervisor (CNS)-A and requested multiple policies and procedures including the above-mentioned policies. On February 5, 2026, at 9:33 a.m., for a second time, the surveyor emailed LALD-D and CNS-A and requested multiple policies and procedures which included the above-mentioned policies. On February 5, 2026, at 6:03 p.m., LALD-D sent an email response to the surveyor which included four policies; however it did not include the above-mentioned policies and procedures. On February 9, 2026, at 7:44 a.m., the surveyor emailed LALD-D and CNS-A requesting if they had any additional policies and procedures to provide which were initially requested on	0 500		

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0 500	Continued From page 10 February 3, 2026. On February 9, 2026, at 4:25 p.m., LALD-D sent an email response to the surveyor which indicated, "No, I do not have additional policies to submit." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 500		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to implement their individual abuse prevention plan (IAPP) policy when they failed to assess the vulnerability of each resident (R1, R2) upon admission to the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 630		

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0 630	Continued From page 11 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted to the licensee on April 29, 2022. R1 was a resident at another assisted living facility (a sister facility to the licensee) prior to their admission to the licensee. R1's Service Plan dated February 2, 2026, indicated R1 received services for medication administration, bathing, dressing, behavior management, and housekeeping. R1's record indicated R1's first IAPP was completed during a comprehensive assessment on May 23, 2022, or 24 days after their date of admission. On February 3, 2026, at 8:07 a.m., the surveyor observed R1 receive medication administration services. R2 R2 was admitted to the licensee on April 28, 2022. R2 was a resident at another assisted living facility (a sister facility to the licensee) prior to their admission to the licensee. R2's Service Plan, undated, indicated R2 received services for medication administration, bathing, dressing, behavior management, and housekeeping.	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38437	A. BUILDING: _____ B. WING _____	02/04/2026

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0 630	Continued From page 12 R2's record indicated R2's first IAPP was completed during a comprehensive assessment on August 27, 2022, or 121 days after their date of admission. On February 3, 2026, at 10:45 a.m., clinical nurse supervisor (CNS)-A stated R1 was transferred to the licensee from one of their other facilities, which held a separate licensee, on April 29, 2022. On February 3, 2025, at 11:01 a.m., CNS-A stated they did not conduct an IAPP assessment for R1 or R2 when they were transferred to the current facility and licensee. The surveyor explained that a resident could not be "transferred" from one licensee to another, the resident would have to be discharged from the previous licensee then admitted to the current licensee. CNS-A stated they were unaware a resident could not be transferred between facilities under different licenses and that a new IAPP should have been completed upon admission. CNS-A stated when R1 and R2 were transferred to the facility they did not treat them as a new admission; they did not conduct an admission assessment or a 14-day assessment. CNS-A stated they continued on with the 90-day assessment schedule and a new IAPP was completed on May 23, 2022, for R1 and on April 27, 2022, for R2. The licensee's Vulnerable Adult policy dated August 1, 2021, indicated, "Assessment of vulnerability status of each resident upon admission." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	0 630		

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0 630	Continued From page 13 days	0 630		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to conduct tuberculosis (TB) testing for one of two employees (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).	0 660		

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0 660	Continued From page 14 The findings include: The licensee's TB risk assessment was completed on October 10, 2025. The licensee was at a low risk level. ULP-C was hired on November 21, 2023, to provide direct care to residents. ULP-C's employee record included a negative CVSHealth Minute Clinic TB Mantoux test result dated January 9, 2019. On February 3, 2026, at 1:03 p.m., clinical nurse supervisor (CNS)-A stated they did not have ULP-C complete a TB test when they were hired. CNS-A stated they were aware of the requirement to complete a TB test at the time of hire for their staff because they received a citation for this scenario during a previous survey and did not make the correction. CNS-A stated the above-mentioned TB test was from prior to ULP-C's date of hire. The Minnesota Department of Health TB FAQ, last updated on October 13, 2025, indicated baseline TB screening is required at the time of hire for all health care personnel in Minnesota which included, "testing for the presence of Mycobacterium tuberculosis by administering either a two-step tuberculin skin test (TST) or single TB blood test." The Regulations for Tuberculosis Control in Minnesota Health Care Settings guide dated July 2013 indicated, "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 before	0 660		

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0 660	Continued From page 15 hire. The second TST may be performed after the HCW starts working with patients." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 800 SS=B	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) 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).	0 800		

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0 800	Continued From page 16 The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated 2/4/2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at	0 810		

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0 810	Continued From page 17 least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated 2/4/2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty one (21) days	0 810		

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0 900	Continued From page 18	0 900		
0 900 SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to execute a written contract on or before the date of admission with the required content for one of two residents (R2).	0 900		

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0 900	Continued From page 19 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R2 was admitted to the licensee on April 28, 2022. R2 was a resident at another assisted living facility (a sister facility to the licensee) prior to their admission to the licensee. R2's Service Plan, undated, indicated R2 received services for medication administration, bathing, dressing, behavior management, and housekeeping. R2's record lacked a signed assisted living contract. On February 3, 2025, at 11:01 a.m., CNS-A stated they were unaware a resident could not be transferred between facilities under different licenses, and a new contract should have been completed with the residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 900		
01320 SS=F	144G.60 Subd. 4 (a) Unlicensed personnel	01320		

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01320	Continued From page 20 (a) Unlicensed personnel providing assisted living services must have: (1) successfully completed a training and competency evaluation appropriate to the services provided by the facility and the topics listed in section 144G.61, subdivision 2, paragraph (a); or (2) demonstrated competency by satisfactorily completing a written or oral test on the tasks the unlicensed personnel will perform and on the topics listed in section 144G.61, subdivision 2, paragraph (a); and successfully demonstrated competency on topics in section 144G.61, subdivision 2, paragraph (a), clauses (5), (7), and (8), by a practical skills test. Unlicensed personnel who only provide assisted living services listed in section 144G.08, subdivision 9, clauses (1) to (5), shall not perform delegated nursing or therapy tasks. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for two of two employees (unlicensed personnel (ULP)-B, ULP-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	01320		

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01320	Continued From page 21 ULP-B ULP-B was hired January 20, 2025, to provide direct care services. The licensee's Staff Listing form dated February 2, 2026, indicated ULP-B was a current employee. On February 2, 2026, at 10:28 a.m., during the facility tour, the surveyor observed ULP-B working. ULP-B's record included an Educare (online training platform) transcript which lacked documentation of the following required competency training and evaluation: - maintenance of a clean and safe environment; and - standby assistance techniques and how to perform them. ULP-C ULP-C was hired on November 21, 2023, to provide direct care to residents. The licensee's Staff Listing form dated February 2, 2026, indicated ULP-C was a current employee. ULP-C's record included an Educare transcript which lacked documentation of the following required competency training and evaluation: - documentation requirements for all services provided; - reports of changes in the resident's condition to the supervisor designated by the assisted living provider; - maintenance of a clean and safe environment; and	01320		

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01320	Continued From page 22 - training on the prevention of falls for providers working with the elderly or individuals at risk of falls. On February 3, 2026, at 1:03 p.m., clinical nurse supervisor (CNS)-A stated all of their training was completed in Educare. CNS-A stated if the training was not completed in Educare, then it wasn't done. On February 4, 2026, at 1:21 p.m., CNS-A stated they were aware of all of the required training topics for competencies and were utilizing Educare to have them completed. CNS-A stated they were in charge of assigning competency training to their ULPs but were having difficulty making sure all of the required training was assigned. A policy addressing competency training and evaluation was requested, but one was not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01320		
01330 SS=F	144G.60 Subd. 4 (b) Unlicensed personnel (b) Unlicensed personnel performing delegated nursing tasks in an assisted living facility must: (1) have successfully completed training and demonstrated competency by successfully completing a written or oral test of the topics in section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5),	01330		

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01330	Continued From page 23 (6), and (7), and all the delegated tasks they will perform; (2) satisfy the current requirements of Medicare for training or competency of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or 484.36; or (3) have, before April 19, 1993, completed a training course for nursing assistants that was approved by the commissioner. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas prior to providing services, for two of two employees (unlicensed personnel (ULP)-B, ULP-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-B ULP-B was hired January 20, 2025, to provide direct cares to residents. The licensee's Staff Listing form dated February 2, 2026, indicated ULP-B was a current employee.	01330		

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01330	Continued From page 24 On February 2, 2026, at 10:28 a.m., during the facility tour, the surveyor observed ULP-B working. ULP-B's record included an Educare (online training platform) transcript which lacked documentation of the following required competency training and evaluation: - reading and recording temperature, pulse, and respirations of the resident; and - range of motion and positioning. ULP-C ULP-C was hired on November 21, 2023, to provide direct cares to residents. The licensee's Staff Listing form dated February 2, 2026, indicated ULP-C was a current employee. ULP-C's record included an Educare (online training platform) transcript which lacked documentation of the following required competency training and evaluation: - observation, reporting, and documenting of resident status; and - reading and recording temperature, pulse, and respirations of the resident. On February 3, 2026, at 1:03 p.m., clinical nurse supervisor (CNS)-A stated all of their training was completed in Educare. CNS-A stated if the training was not completed in Educare, then it wasn't done. On February 4, 2026, at 1:21 p.m., CNS-A stated they were aware of all of the required training topics for competencies and were utilizing Educare to have them completed. CNS-A stated they were in charge of assigning competency	01330		

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01330	Continued From page 25 training to their ULPs but were having difficulty making sure all of the required training was assigned. A policy addressing competency training and evaluation was requested, but one was not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01330		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38437	A. BUILDING: _____ B. WING _____	02/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IMMACULATE HOME INC	29 DARLENE STREET SAINT PAUL, MN 55119

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01500	Continued From page 26 behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received at least eight hours of annual training for each 12 months of employment on required annual training topics for one of two employees who were employed more than 12 months (unlicensed	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01500	Continued From page 27 personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-C was hired on November 21, 2023, to provide direct care to residents. The licensee's Staff Listing form dated February 2, 2026, indicated ULP-C was a current employee. ULP-C's record included an Educare (online training platform) transcript which lacked documentation of the following required competency training and evaluation: - assisted living bill of rights, last completed on September 24, 2024. On February 3, 2026, at 1:03 p.m., clinical nurse supervisor (CNS)-A stated all of their training was completed in Educare. CNS-A stated if the training was not completed in Educare, then it wasn't done. On February 4, 2026, at 1:21 p.m., CNS-A stated they were aware of all of the required annual training topics and were utilizing Educare to have them completed. CNS-A stated they were in charge of assigning annual training to their ULPs but were having difficulty making sure all of the	01500		

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	38437	A. BUILDING: _____ B. WING _____	02/04/2026

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IMMACULATE HOME INC	29 DARLENE STREET SAINT PAUL, MN 55119

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01500	Continued From page 28 required training was assigned. CNS-A stated they were trying to do annual training for all employees at the same time one time per year rather than on employment anniversaries. The licensee's Staff Orientation and Education policy dated August 1, 2021, indicated annual training topics would include, "Review of Assisted Living Bill of Rights and staff responsibilities related to ensuring the exercise and protection of those rights." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01530 SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness	01530		

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	38437	A. BUILDING: _____ B. WING _____	02/04/2026

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01530	Continued From page 29 and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two hours of initial mental illness and de-escalation training was conducted within 160 hours of providing direct care to residents for two of two direct care staff (unlicensed personnel (ULP)-B, ULP-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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).	01530		

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01530	Continued From page 30 The findings include: ULP-B ULP-B was hired on January 20, 2025, to provide direct cares to residents. The licensee's Staff Listing form dated February 2, 2026, indicated ULP-B was a current employee. On February 2, 2026, at 10:28 a.m., during the facility tour, the surveyor observed ULP-B working. ULP-B's record included an Educare (online training platform) transcript which indicated ULP-B completed 0.75 hours of the required two hours of mental illness and de-escalation training within 160 hours of providing direct care services. ULP-C ULP-C was hired on November 21, 2023, to provide direct care to residents. The licensee's Staff Listing form dated February 2, 2026, indicated ULP-C was a current employee. ULP-C's record included an Educare transcript which indicated ULP-C completed one hour of the required two hours of mental illness and de-escalation training within 160 hours of providing direct care services. On February 3, 2026, at 1:03 p.m., clinical nurse supervisor (CNS)-A stated all of their training was completed in Educare. CNS-A stated if the training was not completed in Educare, then it wasn't done.	01530		

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	38437	A. BUILDING: _____ B. WING _____	02/04/2026

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IMMACULATE HOME INC	29 DARLENE STREET SAINT PAUL, MN 55119

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01530	Continued From page 31 On February 4, 2026, at 1:21 p.m., CNS-A stated they were aware of all of the required mental health and de-escalation training topics and were utilizing Educare to have them completed. CNS-A stated they were in charge of assigning annual training to their ULPs but were having difficulty making sure all of the required training was assigned. A policy addressing mental health and de-escalation training was requested, but one was not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01610 SS=F	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective 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	01610		

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	38437	A. BUILDING: _____ B. WING _____	02/04/2026

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IMMACULATE HOME INC	29 DARLENE STREET SAINT PAUL, MN 55119

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01610	Continued From page 32 planning and care delivery. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a comprehensive assessment on, or before, the date of admission when they moved two residents (R1, R2) from a sister facility (under a different license) to the current licensee. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted to the licensee on April 29, 2022. R1 was a resident at another assisted living facility (a sister facility to the licensee) prior to their admission to the licensee. R1's Service Plan dated February 2, 2026, indicated R1 received services for medication administration, bathing, dressing, behavior management, and housekeeping. R1's record lacked an assessment completed on, or before, the date of R1's admission; the first assessment completed for R1 was completed on May 23, 2022, or 24 days after their date of admission.	01610		

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	38437	A. BUILDING: _____ B. WING _____	02/04/2026

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01610	Continued From page 33 On February 3, 2026, at 8:07 a.m., the surveyor observed R1 receive medication administration services. R2 R2 was admitted to the licensee on April 28, 2022. R2 was a resident at another assisted living facility (a sister facility to the licensee) prior to their admission to the licensee. R2's Service Plan, undated, indicated R2 received services for medication administration, bathing, dressing, behavior management, and housekeeping. R2's record lacked an assessment completed on, or before, the date of R2's admission; the first assessment completed for R2 was completed on August 27, 2022, or 121 days after their date of admission. On February 3, 2026, at 10:45 a.m., clinical nurse supervisor (CNS)-A stated R1 was transferred to the licensee from one of their other facilities, which held a separate license, on April 29, 2022. On February 3, 2025, at 11:01 a.m., CNS-A stated they did not conduct an admission assessment for R1 or R2 when they were transferred to the current facility and licensee. The surveyor explained that a resident could not be "transferred" from one licensee to another, the resident would have to be discharged from the previous licensee then admitted to the current licensee. CNS-A stated they were unaware a resident could not be transferred between facilities under different licenses. CNS-A stated when R1 and R2 moved, they did not treat them as a new admission; they did not conduct an	01610		

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	38437	A. BUILDING: _____ B. WING _____	02/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IMMACULATE HOME INC	29 DARLENE STREET SAINT PAUL, MN 55119

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01610	Continued From page 34 admission assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01610		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A	01620		

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	38437	A. BUILDING: _____ B. WING _____	02/04/2026

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01620	Continued From page 35 registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a comprehensive reassessment no more than 14 days after initiation of services and at least every 90 days thereafter for two of two residents (R1, R2). 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).	01620		

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	38437	A. BUILDING: _____ B. WING _____	02/04/2026

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01620	Continued From page 36 The findings include: R1 R1 was admitted to the licensee on April 29, 2022. R1 was a resident at another assisted living facility (a sister facility to the licensee) prior to their admission to the licensee. R1's Service Plan dated February 2, 2026, indicated R1 received services for medication administration, bathing, dressing, behavior management, and housekeeping. R1's record lacked a 14-day assessment completed no more than 14 days after initiation of services; the first assessment completed for R1 was completed on May 23, 2022, or 24 days after their date of admission. R1's Residex (charting software) assessment list indicated Clinical Update 90 Day assessments were completed on June 3, 2025, and October 14, 2025, indicating 133 days had passed between the two assessments. R1's Residex assessment list indicated the next Clinical Update 90 Day assessment was completed on February 2, 2026, (during the survey) indicating 111 days had passed since R1's last assessment on October 14, 2025. On February 3, 2026, at 8:07 a.m., the surveyor observed R1 receive medication administration services. R2 R2 was admitted to the licensee on April 28, 2022. R2 was a resident at another assisted living facility (a sister facility to the licensee) prior to their admission to the licensee.	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38437	A. BUILDING: _____ B. WING _____	02/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01620	Continued From page 37 R2's Service Plan, undated, indicated R2 received services for medication administration, bathing, dressing, behavior management, and housekeeping. R2's record lacked a 14-day assessment completed no more than 14 days after initiation of services; the first assessment completed for R2 was completed on August 27, 2022, or 121 days after their date of admission. R2's Residex assessment list indicated Clinical Update 90 Day assessments were completed on June 16, 2025, and October 14, 2025, indicating 120 days had passed between the two assessments. R2's Residex assessment list indicated the next Clinical Update 90 Day assessment was completed on February 2, 2026, (during the survey) indicating 111 days had passed since R2's last assessment on October 14, 2025. On February 3, 2025, at 11:01 a.m., CNS-A stated they did not conduct a 14-day assessment for R1 or R2 when they were transferred to the current facility and licensee. The surveyor explained that a resident could not be "transferred" from one licensee to another, the resident would have to be discharged from the previous licensee then admitted to the current licensee. CNS-A stated they were unaware a resident could not be transferred between facilities under different licenses. CNS-A stated when R1 and R2 were transferred to the facility they did not treat them as a new admission; they did not conduct a 14-day assessment. CNS-A stated R1 and R2 both had late 90-day assessments. CNS-A stated they had been wanting to use Residex to track when assessments were due but were having difficulty	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38437	A. BUILDING: _____ B. WING _____	02/04/2026

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01620	Continued From page 38 setting up the correct frequency and reminders in the software. CNS-A stated it gets to be a lot trying to keep track of when assessments were due. CNS-A stated they needed to get better at getting assessments completed on time. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by:	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38437	A. BUILDING: _____ B. WING _____	02/04/2026

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01640	Continued From page 39 Based on observation, interview, and record review, the licensee failed to obtain signatures on service plans at the time of admission of a resident and when changes were made to the services for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted to the licensee on April 29, 2022. R1 was a resident at another assisted living facility (a sister facility to the licensee) prior to their admission to the licensee. R1's record lacked a signed service plan at the time of admission. R1's record indicated R1 did not have a signed service plan until January 19, 2026. R1's record included a Service Plan signed on January 19, 2026; it was the only signed service plan in R1's record and indicated they received services for medication administration, bathing, dressing, behavior management, and housekeeping R1's Service Plan dated February 2, 2026, unsigned, indicated R1 received services for medication administration, recording blood glucose, bathing, dressing, behavior	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38437	A. BUILDING: _____ B. WING _____	02/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IMMACULATE HOME INC	29 DARLENE STREET SAINT PAUL, MN 55119

(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
01640	Continued From page 40 management, and housekeeping. R1's Service Plan printed on February 2, 2026, unsigned, indicated R1 received additional services which were not on R1's signed service plan from January 19, 2026. R1 received the following services without a signed service agreement or plan: - recording blood glucose. On February 3, 2026, at 8:07 a.m., the surveyor observed R1 receive medication administration services. R2 R2 was admitted to the licensee on April 28, 2022. R2 was a resident at another assisted living facility (a sister facility to the licensee) prior to their admission to the licensee. R2's Service Plan dated February 3, 2026, unsigned, indicated R2 received services for ambulation, medication administration, bathing, dressing, grooming, meal assistance, safety checks, behavior management, and housekeeping. R2's record lacked a signed service plan. On February 3, 2025, at 11:01 a.m., CNS-A stated they did not treat R1 and R2 like new admissions when they were transferred to the current facility and licensee. The surveyor explained that a resident could not be "transferred" from one licensee to another, the resident would have to be discharged from the previous licensee then admitted to the current licensee. CNS-A stated they were unaware a resident could not be transferred between facilities under different licenses. CNS-A stated	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01640	Continued From page 41 when R1 and R2 were transferred to the facility they did not treat them as a new admission and did not develop a new service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional	01730		

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01730	Continued From page 42 when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and maintain a current individualized medication management plan for each resident based on the resident's assessment at the time of admission for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted to the licensee on April 29,	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01730	Continued From page 43 2022. R1 was a resident at another assisted living facility (a sister facility to the licensee) prior to their admission to the licensee. R1's Service Plan dated February 2, 2026, indicated R1 received services for medication administration. R1's record indicated an individualized medication management plan was not developed until a comprehensive assessment was completed on May 23, 2022, or 24 days after their date of admission. On February 3, 2026, at 8:07 a.m., the surveyor observed R1 receive medication administration services. R2 R2 was admitted to the licensee on April 28, 2022. R2 was a resident at another assisted living facility (a sister facility to the licensee) prior to their admission to the licensee. R2's Service Plan, undated, indicated R2 received services for medication administration. R2's record indicated an individualized medication management plan was not developed until a comprehensive assessment was completed on August 27, 2022, or 121 days after their date of admission. On February 3, 2025, at 11:01 a.m., clinical nurse supervisor (CNS)-A stated they did not develop an individualized medication management plan for R1 or R2 when they were transferred to the current facility and licensee. The surveyor explained that a resident could not be "transferred" from one licensee to another, the	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01730	Continued From page 44 resident would have to be discharged from the previous licensee then admitted to the current licensee and have a new individualized medication management plan developed. CNS-A stated they were unaware a resident could not be transferred between facilities under different licenses. CNS-A stated that when R1 and R2 were transferred to the facility they did not treat them as a new admission; they did not develop an individualized medication management plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01820 SS=F	144G.71 Subd. 13 Prescriptions 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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for two of two residents (R1, R2). 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	01820		

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01820	Continued From page 45 affect a large portion or all of the residents). The findings include: R1 R1 was admitted to the licensee on April 29, 2022. R1 was a resident at another assisted living facility (a sister facility to the licensee) prior to their admission to the licensee. R1's Service Plan dated February 2, 2026, indicated R1 received services for medication administration. On February 3, 2026, at 8:07 a.m., the surveyor observed R1 receive medication administration services. R1's January 2026 Med Admin Summary (medication administration record (MAR)) and Provider Orders form, unsigned and printed on February 3, 2026, indicated R1 took and lacked signed provider's orders for the following: - acetaminophen 500 milligram (mg) tablets, take two tablets (1000mg) by mouth (PO) every six hours as needed (PRN); - certavite-antioxidant, take one tablet PO once daily; - glipizide ER 2.5mg, take one tablet PO in the morning before meals; - loperamide HCL 2mg capsule; take one capsule PO PRN; - lorazepam 2mg tablet, take one tablet PO at bedtime; and - Ozempic 2mg/3 milliliter (ml) injection, inject 2mg SQ once weekly/every Thursday. R2 R2 was admitted to the licensee on April 28, 2022. R2 was a resident at another assisted living	01820		

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01820	Continued From page 46 facility (a sister facility to the licensee) prior to their admission to the licensee. R2's Service Plan dated February 3, 2026, unsigned, indicated R2 received services for ambulation, medication administration, bathing, dressing, grooming, meal assistance, safety checks, behavior management, and housekeeping. R2's record lacked prescriptions for any of their medications. R2's January 2026 Med Admin Summary (MAR) indicated R2 took the following medications: - acetaminophen 500mg tablet, take two tablets PO from dosage box; - albuterol sulfate HFA 108/90, inhale two puffs every four hours PRN; - amlodipine 5mg tablet, take one tablet PO daily; - baclofen 10 mg tablet, take 1/2 tablet (5mg) PO twice daily; - banophen 25mg capsule, take one capsule PO every eight hours PRN; - bupropion HCL ER 200mg tablet, take one tablet PO twice daily; - ferrosol 325 mg tablet, take one tablet PO daily; - hydroxyzine HCL 25mg tablet, take one tablet PO every six hours PRN; - lidocaine 4% pad, apply one patch at 9:00 a.m. and remove patch at 9:00 p.m.; - lidocaine 5% ointment, apply to external areas of pain PRN; - melatonin 3mg tablet, take one tablet (10mg) (sic) PO at bedtime PRN; transcription error; - muscle rub cream, apply to skin one application three times daily PRN; - Narcan 4mg/0.1ml, place one spray into one nostril PRN for suspected overdose, call 911, repeat in opposite nostril in three minutes if no or minimal response	01820		

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01820	Continued From page 47 - omeprazole 20mg tablet, take one tablet PO daily; - tolnaftate 1% cream, apply two times a day between toes PRN; - Ventolin HFA 90 micrograms (mcg), inhale two puffs every four hours PRN; - vitamin B-6 25mg tablet, take one tablet PO daily; and - vitamin D3 1,000u soft gel, take one tablet PO daily. On February 3, 2026, at 11:56 a.m., clinical nurse supervisor (CNS)-A stated when R1 returned from their doctors' appointments they would use their after-visit summaries (AVS) to update R1's medication orders. The surveyor inquired if the AVSs were signed by a provider. CNS-A stated the AVSs were not signed by a provider. CNS-A stated they would go off of the orders given to them by the pharmacy when R1's medications were delivered. The surveyor requested the documents provided to them by the pharmacy. CNS-A stated they might have some of the pharmacy documents for R1, but they might be at their sister facility in another one of R1's charts; they would have to check those records. On February 3, 2026, at 11:59 a.m., CNS-A stated they had a United Community New Escript form with R2's medication orders; the form only included lidocaine and iron tablets and was not signed by a provider. On February 4, 2026, at 1:21 p.m., CNS-A stated they were unable to locate further prescriptions to provide for R1 or R2. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01820	Continued From page 48 days	01820		
01830 SS=D	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prescriptions were renewed at least annually, or every 12 months, for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted to the licensee on April 29, 2022. R1 was a resident at another assisted living facility (a sister facility to the licensee) prior to their admission to the licensee. R1's Service Plan dated February 2, 2026, indicated R1 received services for medication administration. On February 3, 2026, at 8:07 a.m., the surveyor	01830		

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01830	Continued From page 49 observed R1 receive medication administration services. R1's MD Orders (prescriber orders) form signed on June 2, 2022, indicated R1 took the following medications: - atorvastatin calcium 40mg; take one tablet PO once daily; - bupropion hydrochloride (HCL) extended release (ER) 100mg; take one tablet PO once daily, take with bupropion 300mg; - bupropion HCL ER 300mg; take one tablet PO once daily, take with bupropion 300mg, take with bupropion 100mg; - duloxetine HCL 30mg capsule, take three capsules PO every morning; - hydroxyzine HCL 25mg tablet, take one tablet PO three times daily PRN; - metformin HCL ER 500mg, take four tablets (2000mg) PO daily with evening meal; - nystatin powder 100,000 units (u)/ gram (g), apply topically to affected areas two times daily PRN under breast or other location; - prazosin HCL 1mg capsule, take one capsule PO two times daily; - triple antibiotic ointment 1g, apply to affected areas PRN; and - zolpidem tartrate 10mg tablet, take one tablet PO at bedtime PRN. R1's January 2026 Med Admin Summary (medication administration record (MAR)) and Provider Orders form, unsigned and printed on February 3, 2026, indicated R1 took the following medications: - atorvastatin calcium 40mg; take one tablet PO once daily; - bupropion hydrochloride (HCL) extended release (ER) 100mg; take one tablet PO once daily, take with bupropion 300mg;	01830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01830	Continued From page 50 - bupropion HCL ER 300mg; take one tablet PO once daily, take with bupropion 300mg, take with bupropion 100mg; - duloxetine HCL 30mg capsule, take three capsules PO every morning; - hydroxyzine HCL 25mg tablet, take one tablet PO three times daily PRN; - metformin HCL ER 500mg, take four tablets (2000mg) PO daily with evening meal; - nystatin powder 100,000 units (u)/ gram (g), apply topically to affected areas two times daily PRN under breast or other location; - prazosin HCL 1mg capsule, take one capsule PO two times daily; - triple antibiotic ointment 1g, apply to affected areas PRN; and - zolpidem tartrate 10mg tablet, take one tablet PO at bedtime PRN. R1's record lacked prescription renewal every 12 months for the above-mentioned medications; R1's most recent signed prescriptions were dated June 2, 2022. On February 3, 2026, at 11:56 a.m., clinical nurse supervisor (CNS)-A stated they had made multiple attempts to get prescription renewals from R1's provider but the provider never completes them. CNS-A stated when R1 returned from their doctors' appointments they would use after visit summaries (AVS) to update R1's medication orders. The surveyor inquired if the AVSs were signed by a provider. CNS-A stated the AVSs were not signed by a provider. CNS-A stated they would go off of the orders given to them by the pharmacy when R1's medications were delivered. The surveyor requested the documents provided to them by the pharmacy. CNS-A stated they might have some of the pharmacy documents for R1, but they might be at	01830		

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01830	Continued From page 51 their sister facility in another one of R1's charts; they would have to check those records. On February 4, 2026, at 1:21 p.m., CNS-A stated they were unable to locate further prescriptions to provide for R1. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01830		

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

Immaculate Home Inc
29 Darlene Street
St Paul, MN 55119
Ramsey County
Parcel:

Phone:

License Info

License: HFID 38437

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

Inspection Info

Report Number: F8058261037
Inspection Type: Full - Single
Date: 2/2/2026 Time: 11:46:59 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 1
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: CFMP MISSING
Comply By: 4/30/2026 Originally Issued On: 2/2/2026

! **New Order: 3-300B Protection from Contamination: cross-contamination, eggs**
3-302.11A(1) *Priority Level: Priority 1 CFP#: 15*
MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.
COMMENT: OPEN PACKAGE OF RAW BACON HELD IN PRODUCE DRAWER WITH RTE ITEMS
Comply By: Complied On Site Originally Issued On: 2/2/2026

Food & Beverage General Comment

41 STRAWBERRY COOLER
160 DISH MACHINE
41 BACON COOLER

RESIDENTIAL HOME WITH NON COMMERCIAL APPLIANCES AND FINISHES

HRD INSPECTOR JOEY KEEN

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 F8058261037 from 2/2/2026

Establishment Representative

Aaron Gertz,
Public Health Sanitarian 3
651-201-4516
aaron.gertz@state.mn.us

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL38437017	**Date:** 2/4/2026
Facility Name: Immaculate Home Inc	
Facility Address: 29 Darlene Street, St Paul MN 55119	

☒ **TAG IDENTIFICATION: 0800**

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

1. The physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment are in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. [Minn. Stat. 144G.45 subd.2]

   Comments: When the surveyor asked clinical nurse supervisor (CNS)-A to open the window in resident room 4 it was discovered that the handle to operate the egress window was not secured.

   In resident room 3 the closet doors were off track and hanging.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Twenty One (21) days

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

   Comments: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) and P.A.S.S (Pull, Aim, Squeeze, and Sweep). The policy had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility which did not have life safety systems.

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

Comments: During record review CNS-A stated that resident actions were verbal and that there were no written instructions for residents to follow in the event of a fire or similar emergency.