Electronically Delivered

August 26, 2026

Licensee
Solbakken Inc.
16200 37th Avenue North
Plymouth, MN 55446

RE: Project Number(s) SL36006016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 22, 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 . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

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

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.

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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36006	A. BUILDING: _____ B. WING _____	07/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLBAKKEN INC	16200 37TH AVENUE NORTH PLYMOUTH, MN 55446

(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: SL36006016-0 On July 20, 2026, through July 22, 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 six residents: all of whom received services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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 issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an	0 630		

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0 630	Continued From page 1 individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for two of three 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 February 24, 2026, with diagnoses that included essential hypertension, type II diabetes mellitus, hyperlipidemia, morbid obesity, osteoarthritis, malignant neoplasm of corpus uteri, and edema. R1's Service Plan signed and dated February 26, 2026, indicated R1 received services for toileting,	0 630		

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0 630	Continued From page 2 care of hearing aids, medication administration, oral care, position and repositioning, safety checks, shower, and toileting. R1's IAPP completed on July 20, 2026, indicated R1 was not at risk to abuse other vulnerable adults. R1's IAPP indicated R1 was vulnerable due to anxiety/depression/mental illness, vision, and hearing. The IAPP did not indicate specific measures to be taken to minimize the risk. On July 22, 2026, at 11:50 a.m., clinical nurse supervisor (CNS)-C stated the missing content for R1 was an oversight, and they would take it as an educational moment. The Licensee's Vulnerable Adult Maltreatment Policy dated August 1, 2021, indicated each resident receiving services will have a written individualized abuse prevention plan. The plan will include: a. Residents' potential to abuse another individual/vulnerable adult; b. Resident's risk of abusing other vulnerable adults; c. Interventions to minimize the risk of abuse to the residents and other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The	0 650		

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0 650	Continued From page 3 records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records included all required content for three of three employees (unlicensed personnel (ULP)-A, ULP-B, ULP-E). 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:	0 650		

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0 650	Continued From page 4 ULP-A ULP-A was hired on September 4, 2021, to provide direct care and services to residents. ULP-B ULP-B was hired on March 15, 2024, to provide direct care and services to residents. ULP-E ULP-E was hired on February 6, 2020, to provide direct care and services to residents. ULP-A, ULP-B, and ULP-E's employee record lacked documentation that unplanned times away medication training was given to the above-mentioned employees. On July 22, 2026, at 10:54 a.m., clinical nurse supervisor (CNS)-C stated the ULPs would do medication perparation for a resident who was going on unplanned times away from the facility. CNS-C stated they trained the ULPs on how to prepare medication for a resident who was going on unplanned times away from the facility, but they did not have specific documentation for unplanned times away medication preparation training for any employee. CNS-C was not aware they had to do a separate documentation for unplanned times away medication preparation training. On July 22, 2026, at 11:05 a.m., ULP-A stated they were trained on how to prepare medication for resident's unplanned time away from the facility. On July 22, 2026, at 11:06 a.m., ULP-B stated they were trained on how to prepare medication for resident's unplanned time away from the	0 650		

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0 650	Continued From page 5 facility. The licensee's Personnel Records policy dated august 1, 2021, indicated Personnel records will be kept up-to-date, well organized and confidential and will comply with the assisted living law and other relevant laws. The personnel record for each person will include: a. Evidence of current professional licensure, registration or certificate, if licensure, registration, or certification is required by the law or other state requirements; b. Record of orientation; c. Record of all required training for unlicensed personnel and competency evaluations; d. Record of required in-service education for all staff providing services to residents, including annual training and infection control training; e. Documentation of a completed background study; f. Documentation that the employee is not on the OIG or MHCP exclusion list; g. TB screening results (and other documentation related to communicable diseases, if appropriate); h. Results of supervision observations i. Performance evaluations which identify areas of improvement needed and training needs o performance reviews will be conducted at least annually j. Current job description, which includes qualifications, responsibilities and identification of supervisors. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		

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0 680	Continued From page 6	0 680		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents receiving services under the assisted living license. This practice resulted in a level two violation (a	0 680		

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0 680	Continued From page 7 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's undated EPP lacked the following required content: -policies and procedures for subsistence needs for staff and residents; -policies and procedures for medical documents; and -policies and procedures for volunteers. On July 22, 2026, at 11:35 a.m., licensed assisted living director (LALD)-D stated they did not have policy and procedure for volunteers, they had no medical documents policy in the EPP and no documented policy for subsistence needs. LALD-D stated they were not aware of the requirement to include these policies in the EPP. Minnesota Administrative Rule 4659.0100 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 483.72, or successor requirements. This part referenced documents, specifications, methods, and standards in State Operations Manual Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types: Interpretive Guidance. No further information was provided.	0 680		

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0 680	Continued From page 8 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care	0 730		

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0 730	Continued From page 9 professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the resident's record included documentation the licensee consulted the Consumer Product Safety Commission (CSPC) for the most up-to-date information related to portable bed rail recall information for one of one resident (R3) with consumer bed rails. 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: R3's diagnoses included Alzheimer's, age-related nuclear cataract, Hypermetropia bilateral, Presbyopia, and vitreous degeneration	0 730		

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0 730	Continued From page 10 R3's signed service plan (waiver)-Addendum to contract, dated March 29, 2025, indicated R3 received services including assistance with bathing, dressing, medication administration, and safety checks. R3's record included side rail assessment form, dated June 17, 2026, that indicated R3 used bilateral consumer side rails for positioning or support. R3's record also included the manufactures guideline for installation of the side rails. The assessment included Brand/manufactures name and the side rails model number but did not include evidence that the licensee checked the CPSC website for product recalls. On July 22, 2026, at approximately 1:35 p.m., licensed assisted living director/ registered nurse (LALD/RN)-D stated they did check the CPSC website but did not document it. The Minnesota Department of Health (MDH) Resource and Frequently Asked Questions (FAQs) related to consumer bedrails assessment, updated April 17, 2026, indicated that the licensees should refer to the CSPC for the most up-to-date information related to portable bed side rail recall information. The licensee did not provide a policy and procedure for side rails. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		

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0 775	Continued From page 11	0 775		
0 775 SS=C	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in 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 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated July 21, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent	01060		

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01060	Continued From page 12 risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and	01060		

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01060	Continued From page 13 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content for an emergency relocation for one of one resident (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 potential to affect a large portion or all of the residents). The findings include: R2 was admitted to the licensee on November 9, 2023. R2's diagnoses included stroke, aortic valve endocarditis, and bifurcation aneurysm. R2's Service Plan (Private)- Addendum to Contact signed and dated May 4, 2026, indicated R2 received services for toileting, ambulation, bathing assistance, grooming, oral care, nutritional supplement, medication administration, record vitals, shaving, and safety checks. R2's progress notes written on December 14, 2025, by clinical nurse supervisor (CNS)-C indicated R2 was sent to the emergency room due to a skin condition that was later diagnosed as a second-degree burn, and R2 was admitted to the hospital. On July 22, 2026, at 9:50 a.m., CNS-C stated R2 was sent to the hospital mid-December 2025 and	01060		

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01060	Continued From page 14 stayed at the hospital for over a month. R2's record lacked evidence a written notice was provided that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal; and - a notice to the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. On July 22, 2026, at 11:35 a.m., licensed assisted living director (LALD)-D stated she was not planning to relocate R2 to a different facility, therefore they did not send the emergency relocation form to the office of ombudsman. LALD-D further stated they were not aware of the requirement to send a notice to Office of Ombudsman for emergency relocation. LALD-D stated they thought they provided the emergency relocation form to R2's family member (FM)-H. On July 22, 2026, at approximatly 11:40 a.m., FM-H stated they did not receive a written notice as mentioned above.	01060		

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01060	Continued From page 15 On July 10, 2026, at 2:44 p.m., via email the regional Ombudsman indicated there was no emergency relocation notice received from the licensee in the past 24 months. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders;	01500		

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01500	Continued From page 16 (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 observation, interview, and record review, the licensee failed to ensure employees received at least eight hours of annual training for each 12 months of employment with all the required contents for three of three employees (unlicensed personnel (ULP)-A, ULP-B, ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01500		

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01500	Continued From page 17 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-A ULP-A was hired on September 4, 2021, to provide direct care and services to residents. ULP-B ULP-B was hired on March 15, 2024, to provide direct care and services to residents. ULP-E ULP-E was hired on February 6, 2020, to provide direct care and services to residents. On July 21, 2026, at 8:10 a.m., the surveyor observed ULP-A perform medication administration to R1. ULP-A, ULP-B, and ULP-E's employee records lacked evidence that the ULPs had received annual training on a review of provider's policies and procedures. On July 22, 2026, at 1:15 p.m., clinical nurse supervisor (CNS)-C stated none of their employees would have annual training on a review of the provider's policies and procedures. CNS-C was not aware of the requirement to provide a review of the provider's policies and procedures training annually. The licensee's Assisted Living Annual Training	01500		

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01500	Continued From page 18 policy dated August 1, 2021, indicated all assisted living employees will complete annual education on the following topics: a. Reporting of maltreatment of vulnerable adults under section 626.557 b. Assisted living bill or rights c. Staff responsibility related to ensuring exercise and protection in the assisted living bill of rights d. Infection control techniques used in the home and implementation of infection control standards including i. Hand washing ii. Need for and use of protective gloves, gowns, and masks iii. Appropriate disposal of contaminated materials and equipment such as dressings, needles, syringes, and razor blades iv. Disinfecting reusable equipment v. Disinfecting environmental surfaces vi. Reporting communicable diseases e. Effective approaches for problem solving when working with challenging behaviors f. Effective approaches for communication with residents with dementia, Alzheimer's disease or related disorders g. Review of policies and procedures relating to the provision of assisted living services and how to implement them h. Principles of person-centered planning and service delivery i. How person-centered planning and service delivery applies to direct support services provided by staff j. Emergency and disaster training No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01500		

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01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication 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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medication orders were accurately transcribed to the medication administration record for one of three 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 February 24, 2026, with diagnoses that included essential	01760		

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01760	Continued From page 20 hypertension, type II diabetes mellitus, hyperlipidemia, morbid obesity, osteoarthritis, malignant neoplasm of corpus uteri, and edema. R1's Service Plan signed and dated February 26, 2026, indicated R1 received services for toileting, care of hearing aids, medication administration, oral care, position and repositioning, safety checks, and shower. R1's most recent signed physician order dated March 19, 2026, indicated the following orders for Tylenol: 1. start Tylenol 1,000 milligram (mg) by mouth (PO) every morning (q AM) and at bedtime (HS), for pain (do not exceed 3,000 mg/day) 2. start Tylenol 1,000 mg PO PRN (as needed) daily, for pain (do not exceed 3,000 mg/day) 3. discontinue prior Tylenol order R1's medication administration record (MAR) for the month of July 2026, indicated the following order for Tylenol: 1. Tylenol 500 mg take two tablets (1000 mg) by mouth every night; and 2. Tylenol 500 mg take two tablets (1000 mg) by mouth every 6 hours as needed. R1's MAR did not reflect the most recent physician order for Tylenol. In addition, the order indicated to not exceed 3000 mg/ day; the MAR had an order to administer PRN 1000 mg every six hours and an additional 1000 mg every evening. Although the MAR did not indicate the licensee administered above the 3000 mg daily allowance, there was a potential for administration of 5000 mg a day, which would have exceeded the 3000 mg/day limit by 2000 mg.	01760		

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01760	Continued From page 21 On July 22, 2026, at 12:35 p.m., the clinical nurse supervisor (CNS)-C stated the above-mentioned physician order signed and dated March 19, 2026, was the most recent order for R1's Tylenol. CNS-C stated the order did not get transcribed and the previous Tylenol order was not discontinued due to an oversight. CNS-C indicated R1 did not want to take Tylenol twice a day and CNS-C stated they thought they had communicated the resident's need to decrease Tylenol order to once a day at bedtime to the provider, but they did not communicate it to the provider due to an oversight. The licensee's medication management services dated September 1, 2021, indicated the following; 1. The Director of Nursing will determine which medication management services the agency will offer, which may include: a. Medication set ups; b. Administration of medications; c. Storing and securing medications; d. Documenting medication activities; e. Verifying and monitoring effectiveness of systems to ensure safe handling and administration; f. Coordinating refills; g. Handling and implementing changes to prescriptions; h. Communicating with the pharmacy about the client's medications; i. Coordinating and communicating with the prescriber; and j. Communicating with the client, the client's representative and, when appropriate, the client's family. k. The Director of Nursing will identify individual cases in which injections by non-licensed care providers will be considered and carried out. l. This agency will not provide infusion services	01760		

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01760	Continued From page 22 with the exception of patient controlled analgesia utilized at end of life. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. 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 prescription for medications were obtained, and prescriptions were renewed at least every 12 months for one of three residents (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 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).	01970		

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01970	Continued From page 23 The findings include: R2 was admitted to the licensee on November 9, 2023. R2's diagnoses included stroke, aortic valve endocarditis, and bifurcation aneurysm. R2's Service Plan (Private)- Addendum to Contact signed and dated May 4, 2026, indicated R2 received services for toileting, ambulation, bathing assistance, grooming, oral care, nutritional supplement, medication administration, record vitals, shaving, and safety checks. On July 21, 2026, at 9:22 a.m., the surveyor observed unlicensed personnel (ULP)-A perform medication administration and Katefarms - sole -source nutrition formula plain 1.4 CAL/ml administration to R2 via feeding tube. The surveyor asked ULP-A if they had an order for the nutritional supplement. ULP-A showed the surveyor a printed document with the following information: 8:00 a.m., tube feeding 1. 60 CC water flush 2. 1 ¼ c water and 2 boxes of Isosource 3. ½ C water and put 1 empty curamed capsule and crushed pills into ½ C water. Stir well 4. 60 CC water flush (30 CC into each port to clear tubing) 1:00 p.m., tube feeding 1. 60 CC water flush 2. 1 ¼ C water and 2 boxes of Isosource 3. 60 CC water flush (30 CC into each port to clear tubing) 5:30 p.m., tube feeding 1. 60 CC water flush 2. 1 ¼ c water and 2 boxes of Isosource	01970		

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01970	Continued From page 24 3. ½ C water and put 2 emptied curamed capsule and crushed pills into ½ C water. Stir well 4. 60 CC water flush (30 CC into each port to clear tubing) On July 21, 2026, at approximately 9:35 a.m., clinical nurse supervisor (CNS)-C provided the surveyor with a physician order signed and dated December 17, 2025. The order read, "okay to use current G- tube feeding regimen for patient." The surveyor inquired about what the order referred to as a current G-tube regimen. On July 21, 2026, at 10:35 a.m., CNS-C stated they did not have an order from the doctor specifically stating the current order. The current order was what R2's family member ((FM)-H) wanted them to administer to the resident; CNS-C stated they typed it up and showed it to the doctor, the doctor read it during their rounds and wrote it was ok to use it as a current order. CNS-C then provided the surveyor with an order that was written on March 21, 2014, and stated it was the order R2 brought with them to the licensee upon admission. CNS-C stated they did not have any other signed order for the nutritional supplement other than the one ordered in 2014. The signed order dated March 21, 2014, contained the following: Isosource 1.5 or equivalent formula total volume /day 1920 ml rate 480ml/hr for 1 hour or 8 cans/day 7 days per we, 2880 calories/ day total free water 1280 flush before administration with 160ml flush after administration 160ml for one year. On July 22, 2026, at 11:52 a.m., CNS-C provided the surveyor with the following order written and signed by the provider on July 22, 2026, at 5:48 a.m. (during the survey). The order read,	01970		

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01970	Continued From page 25 "1-Type of Feeding: Gravity Formula Name : Katefarms - sole -source nutrition formula plain 1.4 CAL/ml 2- Water flush amount & frequently: 60cc water flush 3 times a day during tube feeding at 8:30-9:00 a.m., midday-12:00 p.m., and then 5:00 p.m. 3- Tube feeding instructions to do before feeding: Staff is to add 1 1/4 cup of water and 2 boxes of Katefarms - sole-source in the morning and at midday-12:00p.m., At 5PM staff is to add 1 1/4 cup of water and 2 box of Katefarms - sole-source at 5:00 p.m. 4-Make sure the patient can tolerate the feed by assessing: no nausea/vomiting no abdominal distention no cramping no diarrhea/ constipation." The licensee's medication management services dated September 1, 2021, indicated the following; 1. The Director of Nursing will determine which medication management services the agency will offer, which may include: a. Medication set ups; b. Administration of medications; c. Storing and securing medications; d. Documenting medication activities; e. Verifying and monitoring effectiveness of systems to ensure safe handling and administration; f. Coordinating refills; g. Handling and implementing changes to prescriptions; h. Communicating with the pharmacy about the client's medications; i. Coordinating and communicating with the prescriber; and j. Communicating with the client, the client's representative and, when appropriate, the client's family. k. The Director of Nursing will identify individual	01970		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLBAKKEN INC	16200 37TH AVENUE NORTH PLYMOUTH, MN 55446

(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
01970	Continued From page 26 cases in which injections by non-licensed care providers will be considered and carried out. l. This agency will not provide infusion services with the exception of patient controlled analgesia utilized at end of life. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		

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

SOLBAKKEN INC
16200 37th Ave N
Plymouth, MN 55446
Hennepin County
Parcel:

Phone:

License Info

License: HFID 36006

Risk:
License:
Expires on:
CFPM: MICHELLE MAISEE THAO
CFPM #: FM68252; Exp: 06/24/2029

Inspection Info

Report Number: F8087261136
Inspection Type: Full - Single
Date: 7/21/2026 Time: 2:00:00 PM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

THIS WAS AN ANNOUNCED AND SCHEDULED FULL INSPECTION.

INSPECTION CONDUCTED IN THE PRESENCE OF HRD NURSE EVALUATOR DEE MOISISSA.

THE FOLLOWING OBSERVATIONS WERE MADE:

CEILING: PAINTED, SMOOTH, APPEARS TO BE DURABLE - COMPLIANT
FLOORS: TILE - COMPLIANT
COUNTERTOPS: QUARTZ - COMPLIANT
CABINETS: WOOD - NON COMPLIANT
REFRIGERATOR/FREEZER: UPSTAIRS KITCHEN - KENMORE - BASEMENT KITCHENETTE - GE
DISHWASHER: KITCHEN-AID
STOVE/RANGE: KENMORE
MICROWAVE: NONE
HAND WASHING SINK: YES - SEPERATE DESIGNATED HAND WASHING SINK

NON COMPLIANT CABINETS ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

DISHWASHER IS RESIDENTIAL BUT HAS SANITIZING RINSE CYCLE OPTION. TEMPERATURE STRIPS USED TO ENSURE UTENSIL SURFACE TEMPERATURES REACH 165.

HOT WATER TEMPERATURE AT THE KITCHEN SINK REACHED 120 DEGREES.

INSPECTION REPORT EMAILED TO FACILITY AND HRD NURSE SURVEYOR.

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 F8087261136 from 7/21/2026

John Boettcher

MICHELLE MAISEE THAO
CFPM

John Boettcher,
Public Health Sanitarian 3
651-201-5076
john.boettcher@state.mn.us

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

Temperature Observations/Recordings

Establishment Info

SOLBAKKEN INC
Plymouth
County/Group: Hennepin County

Inspection Info

Report Number: F8087261136
Inspection Type: Full
Date: 7/21/2026
Time: 2:00:00 PM

Equipment Temperature: Product/Item/Unit: AMBIENT AIR**; Temperature Process:** Ambient Air
Location: Upright Freezer at 12 Degrees F.
Comment: UPSTAIRS KITCHEN
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: AMBIENT AIR**; Temperature Process:** Ambient Air
Location: Upright Cooler at 40 Degrees F.
Comment: UPSTAIRS KITCHEN
Violation Issued?: No

Food Temperature: Product/Item/Unit: YOGURT**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 40 Degrees F.
Comment: UPSTAIRS KITCHEN
Violation Issued?: No

Food Temperature: Product/Item/Unit: MILK**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 40 Degrees F.
Comment: UPSTAIRS KITCHEN
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: AMBIENT AIR**; Temperature Process:** Ambient Air
Location: Upright Freezer at 13 Degrees F.
Comment: BASEMENT KITCHENETTE
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: AMBIENT AIR**; Temperature Process:** Ambient Air
Location: Upright Cooler at 41 Degrees F.
Comment: BASEMENT KITCHENETTE
Violation Issued?: No

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL36006016-0	**Date:** 7/21/2026
Facility Name: SOLBAKKEN INC	
Facility Address: 16200 37TH AVENUE NORTH, PLYMOUTH, MN	

☒ **TAG IDENTIFICATION: 0775**

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

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

2. A means of egress shall be free from obstructions that would prevent its use, including the accumulation of snow and ice. Means of egress shall remain free of any material or matter where its presence would obstruct or render the means of egress hazardous. No combustible material storage is allowed in the corridors or exit stairs. [Minn. Stat. 144G.45 subd. 2; MSFC 1031.3]

   Comments: The stairway had "baby gates" at the top and bottom of the stairway to prevent the residents from using the stairway.