Electronically Delivered

October 15, 2026

Licensee
Esteem Home Health Services
4024 Idaho Avenue
Crystal, MN 55427

RE: Project Number(s) SL37006016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 20, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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

0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,500.00**. 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.

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,



Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 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
	37006	A. BUILDING: _____ B. WING _____	08/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESTEEM HOME HEALTH SERVICES	4024 IDAHO AVENUE CRYSTAL, MN 55427

(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: SL37006016-0 On August 17, 2026, through August 20, 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 was one resident; one receiving services under the Assisted Living Facility license. On August 19, 2026, an immediate correction order was issued for tag identification 2310. During the course of the survey, the licensee failed to take action to mitigate the imminent risk.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 430 SS=A	144G.40 Subd. 2 Uniform checklist disclosure of services	0 430		

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0 430	Continued From page 1 (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) to one of three residents (R1). 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 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 on June 11, 2026, and began	0 430		

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0 430	Continued From page 2 receiving assisted living services. R1's unsigned Service Plan Waiver indicated R1's services included assistance with appointments, behavior management, and vital signs. R1's record lacked authenticated acknowledgement, by the resident, that a copy of the licensee's UDALSA had been received. On August 17, 2026, at 11:32 a.m., LALD-A stated R1 did not have a signed acknowledgement of receiving a UDALSA in her records. LALD-A stated they had given the information to R1, who refused to sign and had given the information to her case manager. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 430		
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;	0 470		

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0 470	Continued From page 3 (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; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to implement a staffing plan to determine staffing levels to meet the needs of all residents and failed to evaluate that plan at least twice a year. Additionally, the licensee failed to ensure the 24-hour staffing schedule was posted as required, potentially affecting all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: STAFFING PLAN On August 17, 2026, at 3:38 p.m., licensed	0 470		

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0 470	Continued From page 4 assisted living director (LALD)-A emailed the facility staffing plan to the surveyor. The licensee's undated Staffing Management and Contingency Staffing Plan lacked documentation that the plan had been reviewed twice per year and did not include authentication of who developed the plan. On August 18, 2026, at 8:39 a.m., LALD-A stated the staffing plan had not been reviewed twice per year. LALD-A (who is not the clinical nurse supervisor) stated, "I can sign it now". DAILY STAFFING SCHEDULE During the facility tour on August 17, 2026, at 10:57 a.m., the surveyor observed a posted weekly schedule dated June 2026. On August 17, 2026, at 1:07 p.m., house manager (HM)-E stated the posted weekly schedule was incorrect because the printer was not working. Minnesota Administrative Rule 4659.0180, Subpart 3 dated August 11, 2021, indicated the clinical nurse supervisor must develop and implement a written staffing plan that provided an adequate number of qualified direct-care staff to meet the residents' needs 24 hours a day, seven days a week. When developing a direct-care staffing plan, the clinical nurse supervisor must ensure that staffing levels were adequate to address the following: a. each resident's needs, as identified in the resident's service plan and assisted living contract; b. each resident's acuity level, as determined by the most recent assessment or individualized review;	0 470		

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0 470	Continued From page 5 c. the ability of staff to timely meet the residents' scheduled and reasonably foreseeable unscheduled needs given the physical layout of the facility premises; d. whether the facility has a secured dementia care unit; and e. staff experience, training, and competency. Minnesota Rule 4659.0180 Subpart 4 indicated the daily work schedule must be posted in a central location accessible to staff, residents, and the public. The licensee's Staffing Policy dated August 1, 2021, indicated the administrator and clinical director would review staffing adequacy at least twice annually. 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	0 480		

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0 480	Continued From page 6 supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are 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.	0 480		

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0 480	Continued From page 7 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated August 18, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and	0 510		

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0 510	Continued From page 8 Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program that complied with accepted health care, medical and nursing standards for infection control. The deficient practice had the potential to affect residents, employees, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: ENVIRONMENTAL CLEANLINESS On August 18, 2026, at 3:00 p.m., the surveyor observed a slow draining sink in the main level bathroom. Also, the bathroom lacked soap, hand sanitizer, and paper towels. On August 18, 2026, at 3:30 p.m., the slow draining sink, and lack of soap and paper towels in the main bathroom was brought to the attention of licensed assisted living director (LALD)-A by the surveyor. LALD-A stated someone was	0 510		

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0 510	Continued From page 9 coming to repair the sink. On August 19, 2026, at 12:30 p.m., the surveyor observed the sink in the main floor bathroom was plugged with a sink full of water. The soap bottle and paper towel dispenser remained empty. On August 19, 2026, at 2:30 p.m., LALD-A stated someone was coming to fix the bathroom sink. HANDWASHING ULP-C was hired on October 11, 2025, and began providing assisted living services. ULP-C's record included a Home Health Aide Medication Competency Evaluation dated October 11, 2025. The competency evaluation indicated ULP-C had demonstrated competency with hand washing and was signed by a registered nurse (RN). On August 19, 2026, at 9:22 a.m., the surveyor observed unlicensed personnel (ULP)-C preparing and administering medications to R1. During medication preparation, ULP-C was observed to pour pills from bottles into an ungloved hand before placing the pills in a medication cup. Hand hygiene was not observed before or after medication preparation or administration. On August 19, 2026, at 9:30 a.m., ULP-C stated they had been trained to administer medications by a nurse who no longer worked for the licensee. ULP-C stated they could not remember the nurse's name. On August 19, 2026, at 9:42 a.m., the surveyor observed ULP-C take a blood pressure reading on R1. Hand hygiene was not observed before or	0 510		

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0 510	Continued From page 10 after checking R1's blood pressure. On August 19, 2026, at 2:45 p.m., RN-F stated they trained staff on medication administration. RN-F stated they could not remember specifically if they had provided training for ULP-C, but they "watched the staff do their jobs." On August 19, 2026, at 2:45 p.m., LALD-A stated three different nurses were responsible for training staff members. The licensee's Handwashing policy dated August 1, 2021, indicated handwashing would be performed by all employees, as necessary, between tasks and procedures, and after bathroom use, to prevent cross-contamination. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse.	0 630		

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0 630	Continued From page 11 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop an individual abuse prevention plan (IAPP) with the required content 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). The findings include: R2 was admitted to the licensee on June 10, 2026, and discharged on July 19, 2026. R2's unsigned Service Plan (Private) dated August 18, 2026, indicated R2's services included assistance with medication administration, safety checks, behavior management, and observations for drug paraphernalia. R2's IAPP completed on June 11, 2026, lacked an assessment of R2's risk of abusing other vulnerable adults with statements of measures to be taken to minimize the risk. On August 19, 2026, at 2:26 p.m., registered nurse (RN)-F stated she had completed the IAPP for R2. RN-F stated they did not realize required information was missing from the plan. The licensee's undated Abuse Prevention Plan policy indicated all residents would be assessed	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37006	A. BUILDING: _____ B. WING _____	08/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESTEEM HOME HEALTH SERVICES	4024 IDAHO AVENUE CRYSTAL, MN 55427

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0 630	Continued From page 12 for their susceptibility to abuse by other individuals and their risk of abusing other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 660 SS=F	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 establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included baseline testing for three of three employees (unlicensed personnel (ULP)-B, ULP-C, registered nurse (RN)-D).	0 660		

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	37006	A. BUILDING: _____ B. WING _____	08/20/2026

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0 660	Continued From page 13 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 Facility TB Risk Assessment Worksheet dated June 19, 2026, indicated the facility was at a low TB risk. ULP-B ULP-B was hired on May 17, 2024, and began providing assisted living services. ULP-B's employee record included a Tuberculosis Annual Risk Assessment Screening Questionnaire dated May 16, 2024. ULP-C ULP-C was hired on October 11, 2025, and began providing assisted living services. ULP-C's employee record included a Tuberculosis Annual Risk Assessment Screening Questionnaire dated October 7, 2025. RN-D RN-D was hired on October 27, 2023, and began providing assisted living services. RN-D's employee record included a Tuberculosis Annual Risk Assessment Screening Questionnaire dated October 27, 2025.	0 660		

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	37006	A. BUILDING: _____ B. WING _____	08/20/2026

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0 660	Continued From page 14 ULP-B, ULP-C, and RN-D's employee records lacked evidence of a two-step tuberculin skin test (TST) or a TB blood test. On August 19, 2026, at 9:07 a.m., licensed assisted living director (LALD)-A stated statute indicated that employees no longer needed TB tests. LALD-A stated he would check the office and provide documentation if he "could find it". No additional employee TB documentation was provided to the surveyor prior to the survey closing. The licensee's undated Tuberculosis Screening policy indicated each employee would have documentation of baseline health symptom screening and a TB skin test, or negative blood test, prior to providing care to residents. The Minnesota Department of Health (MDH) guidelines Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013 and based on CDC guidelines indicated employee baseline screening included three components: -assessing for current symptoms of active TB disease; -assessing TB history; and -testing for the presence of TB infection by administering either a two-step TST or a single TB blood test. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		

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	37006	A. BUILDING: _____ B. WING _____	08/20/2026

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0 680	Continued From page 15	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 observation, 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 violation that did not harm a resident's health or	0 680		

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	37006	A. BUILDING: _____ B. WING _____	08/20/2026

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0 680	Continued From page 16 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 EPP review page dated February 29, 2024, lacked the following required content: - annual EPP and hazard vulnerability assessment updates; -EPP resident population; -process for emergency preparedness collaboration; -policies and procedures for subsistence needs for staff and residents; -policies and procedures for tracking staff and residents; -policies and procedures for sheltering in place; -policies and procedures for medical documents; -policies and procedures for volunteers; -policies and procedures for roles under a waiver declared by secretary; -development of a communication plan; -names and contact information; -emergency officials contact information; -a quarterly review of the missing resident plan; -procedure for sharing information on occupancy and or needs; and -emergency prep testing requirements; On August 19, 2026, at 2:26 p.m., licensed assisted living director (LALD)-A stated they were unaware of missing content in the EPP. LALD-A stated they did not complete two emergency preparedness drills per year and did not know that it was required.	0 680		

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0 680	Continued From page 17 The licensee's Emergency Preparedness policy dated August 1, 2021, indicated the licensee would have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. The policy referenced CMS State Operations Manual Appendix Z and Minnesota Rules 4650.0100. The licensee's Missing Resident policy dated August 1, 2021, indicated the missing resident procedure would be reviewed by the director and clinical nurse supervisor at least quarterly and changes to the plan would be documented. 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. Minnesota Administrative Rule 4659.0110 subpart 4 dated August 11, 2021, indicated the assisted living director and clinical nurse supervisor would review the missing resident plan at least quarterly and document and changes to the plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		

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0 730	Continued From page 18	0 730		
0 730 SS=F	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 professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received	0 730		

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0 730	Continued From page 19 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 interview and record review, the licensee failed to ensure the resident records included documentation of services provided for three of three residents (R1, R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R1 R1 was admitted on June 11, 2026, and began receiving assisted living services. R1's unsigned Service Plan Waiver dated August 3, 2026, indicated R1's services included assistance with appointments, behavior management, and vital signs. R1's Service Recap Summary dated July 2026, lacked documentation of services provided for the	0 730		

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0 730	Continued From page 20 following services and dates: -appointment reminders on July 2, 3, 4, 5, 8, 9, 11, 12, 13, 22, 25, 26, 29, 30, and 31, 2026; -behavior management - Agitation on July 1, 2, 3, 4, 5, 6, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, and 31, 2026; -pain documentation on July 1, 2, 3, 4, 5, 7, 8, 9, 11, 12, 13, 14, 16, 17, 22, 25, 26, 29, 30, and 31, 2026; and -documentation of vital signs on July 2, 4, 5, 8, 11, 12, 13, 14, 18, 22, 25, 26, 29, 30, and 31, 2026. R2 R2 was admitted to the licensee on June 10, 2026, and discharged on July 19, 2026. R2's unsigned Service Plan (Private) dated August 18, 2026, indicated R2's services included assistance with medication administration, safety checks, behavior management, and observations for drug paraphernalia. R2's Service Recap Summary dated July 2026, lacked documentation of services provided for the following services and dates: -bathing reminders on July 2, 4, 5, 8, 10, 11, 12, 13, 15, and 17, 2026; -observation for drug paraphernalia on July 1, 2, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, and 17, 2026; -assistance with grooming on July 2, 4, 5, 8, 10, 11, 12, 13,15, and 17, 2026; -housekeeping on July 2, 4, 5, 8, 10, 11, 12, 13,15, and 17, 2026; -laundry on July 6, 10, 13, and 17, 2026; -manage behavior, sexual inappropriateness on July 1, 2, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, and 17, 2026; -manage behavior, verbal aggression on July 2,	0 730		

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0 730	Continued From page 21 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, and 17, 2026; -manage behavior, substance abuse on July 1, 2, 4, 5, 6, 7, 8, 9, 11, 12, 13, 14, 15, 16, and 17, 2026; -manage symptoms, delusions on July 1, 2, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, and 17, 2026; -safety checks on July 2, 4, 5, 7, 8, 9, 11, 12, 13, and 14, 2026; and -vital signs on July 2, 4, 5, 8, 11, 12, 13, and 14, 2026. R3 R3 was admitted to the licensee on July 25, 2026, and discharged on August 7, 2026. R3's unsigned Service Plan (Private) dated August 18, 2026, indicated R3's services included medication administration. R3's Service Recap Summary dated July 2026, lacked documentation that medication administration was provided on July 25, 26, 27, 28, 29, 30, and 31, 2026. R3's Service Recap Summary dated August 2026, lacked documentation that medication administration was provided on August 1, 2, 3, 4, 5, 6, and 7, 2026. On August 19, 2026, at 2:26 p.m., registered nurse (RN)-F stated they were unaware that documenttion was missing from the service logs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		

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0 900	Continued From page 22	0 900		
0 900 SS=E	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 interview and record review, the licensee failed to develop and execute a written assisted living contract prior to providing services	0 900		

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	37006	A. BUILDING: _____ B. WING _____	08/20/2026

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0 900	Continued From page 23 for two of three 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 pattern scope (when more than a limited number of resident's are affected, more than a limited number of staff are involved or the situation has occurred repeatedly, but is not found to be pervasive). The findings include: R1 R1 was admitted on June 11, 2026, and began receiving assisted living services. R1's unsigned Service Plan Waiver dated August 3, 2026, indicated R1's services included assistance with appointments, behavior management, and vital signs. R2 R2 was admitted to the licensee on June 10, 2026, and was discharged on July 19, 2026. R2's unsigned Service Plan (Private) dated August 18, 2026, indicated R2's services included assistance with medication administration, safety checks, behavior management, and observations for drug paraphernalia. R1 and R2's records lacked a written contract signed by the licensee and the resident or resident's representative. On August 18, 2026, at 10:25 a.m., licensed assisted living director (LALD)-A stated they had	0 900		

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0 900	Continued From page 24 given R1 a contract to sign and R1 had given the contract to her case manager. LALD-A also stated R2 did not have a signed contract since he "was never admitted and was not a resident". The licensee's undated Assisted Living Contracts policy indicated the licensee would establish a contract with each resident at the time of admission. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 900		
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 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	01060		

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ESTEEM HOME HEALTH SERVICES	4024 IDAHO AVENUE CRYSTAL, MN 55427

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01060	Continued From page 25 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 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 and failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation for two of two discharged residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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).	01060		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37006	A. BUILDING: _____ B. WING _____	08/20/2026

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ESTEEM HOME HEALTH SERVICES	4024 IDAHO AVENUE CRYSTAL, MN 55427

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01060	Continued From page 26 The findings include: R2 R2 was admitted to the licensee on June 10, 2026, and was discharged on July 19, 2026. R2's unsigned Service Plan (Private) dated August 18, 2026, indicated R2's services included assistance with medication administration, safety checks, behavior management, and observations for drug paraphernalia. R2's Resident Notes dated July 18, 2026, at 9:50 p.m., indicated R2 was transferred to the hospital after notifying the police that he did not feel safe in the facility. R3 R3 was admitted to the licensee on July 25, 2026, and discharged on August 7, 2026. R3's unsigned Service Plan (Private) dated August 18, 2026, indicated R3's services included medication administration. R3's Resident Notes dated August 7, 2026, indicated R3 was transferred to the hospital for emergency psychiatric care. R2 and R3's records lacked a written notice 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	01060		

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	37006	A. BUILDING: _____ B. WING _____	08/20/2026

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01060	Continued From page 27 that a return date is not currently known; - a statement that, if the facility refuses to provide housing or services after relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the residents may submit an appeal. In addition, R2 and R3's records lacked notification to the Office of Ombudsman for Long-Term Care within four days that R2 and R3 had been relocated and had not returned to the facility. On August 18, 2026, at 10:25 a.m., licensed assisted living director (LALD)-A stated they did not send an emergency notice for R2 or R3's hospitalizations and had not contacted the Office of the Ombudsman for Long-Term Care. LALD-A stated it "would be corrected going forward". The licensee's undated Assisted Living Contract Terminations policy indicated that in the event of an emergency relocation, the licensee would provide a written notice that contains: -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 relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the residents may submit an	01060		

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01060	Continued From page 28 appeal. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01070 SS=F	144G.52 Subd. 10 Right to return If a resident is absent from a facility for any reason, including an emergency relocation, the facility shall not refuse to allow a resident to return if a termination of housing has not been effectuated. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to allow two of two residents (R2, R3) to return to the facility after hospitalization without having issued a termination notice. 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 R2 was admitted to the licensee on June 10, 2026, and was discharged on July 19, 2026. R2's unsigned Service Plan (Private) dated	01070		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01070	Continued From page 29 August 18, 2026, indicated R2's services included assistance with medication administration, safety checks, behavior management, and observations for drug paraphernalia. R2's Resident Notes dated July 18, 2026, at 9:50 p.m., indicated R2 was transferred to the hospital after notifying the police that he did not feel safe in the facility. R3 R3 was admitted to the licensee on July 25, 2026, and discharged on August 7, 2026. R3's unsigned Service Plan (Private) dated August 18, 2026, indicated R3's services included medication administration. R3's Resident Notes dated August 7, 2026, indicated R3 was transferred to the hospital for emergency psychiatric care. R2 and R3's records lacked documentation of a contract termination process. On August 17, 2026, at 2:14 p.m., house manager (HM)-C stated R2 had not yet returned from the hospital. HM-C stated R2 had made verbal threats to others and licensee did not want to allow him back to the facility. On August 18, 2026, at 10:35 a.m., licensed assisted living director (LALD)-A stated R2 and R3 were "not really residents" as they had not completed all admission paperwork. LALD-A stated they did not initiate the process to terminate services for R2 or R3. LALD-A stated R2 did not have a case manager, and he did not know who to contact. LALD-A stated he had communicated via text messages and email with	01070		

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01070	Continued From page 30 R3's case manager and would provide copies of that communication to the surveyor. Copies of text messages and email were not received by the end of the survey. The licensee's undated Assisted Living Contract Terminations policy indicated that if a resident is absent from a facility for any reason, including an emergency relocation, the facility would not refuse to allow a resident to return if a termination of housing has not been effectuated. No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	01070		
01320 SS=F	144G.60 Subd. 4 (a) Unlicensed personnel (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.	01320		

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	37006	A. BUILDING: _____ B. WING _____	08/20/2026

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01320	Continued From page 31 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure required training was completed and documented 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: On August 18, 2026, at 8:05 a.m., the surveyor observed ULP-B monitoring vital signs and administering medications to R1. On August 19, 2026, at 9:22 a.m., the surveyor observed ULP-C monitoring vital signs and administering medications to R1. ULP-B was hired on May 17, 2024, and began providing assisted living services. ULP-C was hired on October 11, 2025, and began providing assisted living services. ULP-B and ULP-C's employee records lacked documentation of required competencies to include: -appropriate and safe techniques in personal hygiene and grooming, including: -haircare and bathing	01320		

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01320	Continued From page 32 -care of teeth, gums, and oral prosthetic devices; -care and use of hearing aids; -dressing and assisting with toileting; and -standby assistance techniques and how to perform them. On August 19, 2026, at 2:38 p.m., registered nurse (RN)-F stated she did not remember if she had validated competencies for ULP-B and ULP-C. RN-F stated she "watched them do their jobs". The licensee's undated Qualifications, Training, and Competency policy indicated training and competency evaluations for all unlicensed personnel would include: -appropriate and safe techniques in personal hygiene and grooming, including: -haircare and bathing -care of teeth, gums, and oral prosthetic devices; -care and use of hearing aids; -dressing and assisting with toileting; and -standby assistance techniques and how to perform them. 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	01330		

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01330	Continued From page 33 section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform; (2) satisfy the current requirements of Medicare for training or competency of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or 484.36; or (3) have, before April 19, 1993, completed a training course for nursing assistants that was approved by the commissioner. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure required training was completed and documented 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: ULP-B On August 18, 2026, at 8:05 a.m., the surveyor observed ULP-B monitoring vital signs and administering medications to R1.	01330		

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01330	Continued From page 34 ULP-B was hired on May 17, 2024, and began providing assisted living services. ULP-B's employee record lacked documentation of required competencies to include: -reading and recording temperature, pulse, and respirations of the resident; -safe transfer techniques and ambulation; and -range of motion and positioning. ULP-C On August 19, 2026, at 9:22 a.m., the surveyor observed ULP-C monitoring vital signs and administering medications to R1. ULP-C was hired on October 11, 2025, and began providing assisted living services. ULP-C's employee record lacked documentation of required training to include: -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; and -recognizing physician, emotional, cognitive, and developmental needs of the residents. ULP-C's employee record lacked documentation of required competencies to include: -reading and recording temperature, pulse, and respirations of the resident; -safe transfer techniques and ambulation; and -range of motion and positioning. On August 19, 2026, at 2:38 p.m., registered nurse (RN)-F stated she did not remember if she had validated competencies for ULP-B and ULP-C. RN-F stated she "watched them do their jobs".	01330		

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01330	Continued From page 35 On August 19, 2026, at 2:39 p.m., licensed assisted living director (LALD)-A stated he was responsible for assigning the online education modules and was not aware that all required modules were not assigned. The licensee's undated Qualifications, Training, and Competency policy indicated training and competency evaluations for all unlicensed personnel would include: -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; -reading and recording temperature, pulse, and respirations of the resident; -recognizing physician, emotional, cognitive, and developmental needs of the residents; -safe transfer techniques and ambulation; and -range of motion and positioning. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01330		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment	01440		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37006	A. BUILDING: _____ B. WING _____	08/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01440	Continued From page 36 administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure supervision was completed within 30 calendar days after hire and beginning to provide the delegated tasks to residents for two of two 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: On August 18, 2026, at 8:05 a.m., the surveyor observed ULP-B monitoring vital signs and administering medications to R1. On August 19, 2026, at 9:22 a.m., the surveyor	01440		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01440	Continued From page 37 observed ULP-C monitoring vital signs and administering medications to R1. ULP-B was hired on May 17, 2024, and began providing assisted living services. ULP-C was hired on October 11, 2025, and began providing assisted living services. ULP-B and ULP-C's employee records lacked documentation of direct supervision, by a registered nurse (RN), of delegated tasks within 30 days of hire or beginning to provide delegated tasks to residents. On August 19, 2026, at 8:00 a.m., the surveyor received a 30-Day Staff Performance Review dated December 19, 2026, for ULP-C. The performance review lacked documentation that a delegated task was observed. On August 19, 2026, at 2:30 p.m., RN-F stated they were unaware that 30-day supervision needed to be completed on delegated tasks. RN-F stated she "watched them do their jobs". On August 19, 2026, at 3:35 p.m., licensed assisted living director (LALD)-A stated the 30-day Staff Performance Review form was intended to be the 30-day supervision. The licensee's undated Supervision of Unlicensed Personnel policy indicated supervision of staff performing medication or treatment administration would be provided by a registered nurse within 30 calendar days after the date of which the individual begins working for the facility and first performs the delegated tasks for residents.	01440		

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01440	Continued From page 38 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and	01470		

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ESTEEM HOME HEALTH SERVICES	4024 IDAHO AVENUE CRYSTAL, MN 55427

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01470	Continued From page 39 the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation 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 the challenges it poses to communication; (2) 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 orientation to include all required content 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 is issued at a widespread scope (when problems	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37006	A. BUILDING: _____ B. WING _____	08/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01470	Continued From page 40 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 was hired on May 17, 2024, and began providing assisted living services. ULP-B's employee record lacked documentation that ULP-B had received an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person. ULP-C was hired on October 11, 2025, and began providing assisted living services. ULP-C's employee record lacked documentation of the following required orientation topics: -compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); and -an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person. On August 19, 2026, at 2:39 p.m., licensed assisted living director (LALD)-A stated he was responsible for assigning the online education modules and was not aware that all required topics were not included in the licensee's orientation program. The licensee's undated Facility Employee Orientation policy indicated orientation topics would include: -reporting the maltreatment of vulnerable minors	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37006	A. BUILDING: _____ B. WING _____	08/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESTEEM HOME HEALTH SERVICES	4024 IDAHO AVENUE CRYSTAL, MN 55427

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01470	Continued From page 41 or adults under the Minnesota statutes 626.556 and 626.557; and -an introduction and review of the facility's policies and procedures related to the provision of home care services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
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	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37006	A. BUILDING: _____ B. WING _____	08/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESTEEM HOME HEALTH SERVICES	4024 IDAHO AVENUE CRYSTAL, MN 55427

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01500	Continued From page 42 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 staff performing direct-care services received a minimum of eight (8) hours of annual training per twelve (12) months of employment for one of two employees (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a	01500		

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	37006	A. BUILDING: _____ B. WING _____	08/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESTEEM HOME HEALTH SERVICES	4024 IDAHO AVENUE CRYSTAL, MN 55427

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01500	Continued From page 43 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-B was hired on May 17, 2024, and began providing assisted living services. ULP-B's Educare (online training) transcript dated August 18, 2026, indicated ULP-B had completed the following required annual training content in December 2025: -Vulnerable Adult Refresher-MN for three quarter (0.75) hours; -Assisted living Bill of Rights for 0.75 hours; -Infection Control Techniques for one (1) hour; and -Person Centered Care Principles for 0.5 (one half) hour. ULP-B's employee record lacked documentation that 8 hours of annual training had been completed within 12 months of employment, to include the following required content: -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; and -review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures.	01500		

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	37006	A. BUILDING: _____ B. WING _____	08/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESTEEM HOME HEALTH SERVICES	4024 IDAHO AVENUE CRYSTAL, MN 55427

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01500	Continued From page 44 On August 18, 2026, at 2:40 p.m. licensed assisted living director (LALD)-A stated he was responsible for assigning annual training modules to employees. LALD-A stated he was unaware that all content was not assigned. LALD-A also stated they did not know that 8 hours of annual training was required for each 12 months of employment. The licensee's undated Annual Training Requirements policy indicated staff providing direct care services would complete at least 8 hours of annual training for each 12 months of employment to include the following required content: -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; and -review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures. 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)	01530		

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	37006	A. BUILDING: _____ B. WING _____	08/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESTEEM HOME HEALTH SERVICES	4024 IDAHO AVENUE CRYSTAL, MN 55427

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01530	Continued From page 45 to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the 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 interview and record review, the licensee failed to ensure dementia, mental illness, and de-escalation training was completed within	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37006	A. BUILDING: _____ B. WING _____	08/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESTEEM HOME HEALTH SERVICES	4024 IDAHO AVENUE CRYSTAL, MN 55427

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01530	Continued From page 46 the required timeframe by two of two employees (unlicensed personnel (ULP)-B, ULP-C). Additionally, the licensee failed to ensure that two of two employees (ULP-B, registered nurse (RN)-D) had completed at least two (2) hours of training on topics related to dementia/mental illness for each twelve (12) months of employment thereafter. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-B ULP-B was hired on May 17, 2024, and began providing assisted living services. ULP-B's employee record lacked documentation that ULP-B had completed eight (8) hours of dementia care training and two (2) hours of mental illness and de-escalation training within 160 hours of start date. ULP-B's record lacked documentation that 2 hours of dementia care training and one hour of mental illness training with de-escalation topics was completed with annual education. ULP-C ULP-C was hired on October 11, 2025, and began providing assisted living services.	01530		

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	37006	A. BUILDING: _____ B. WING _____	08/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESTEEM HOME HEALTH SERVICES	4024 IDAHO AVENUE CRYSTAL, MN 55427

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01530	Continued From page 47 ULP-C's employee record lacked documentation that ULP-B had completed eight (8) hours of dementia care training and two (2) hours of mental illness and de-escalation training within 160 hours of start date. RN-D RN-D was hired October 27, 2023, and began providing assisted living services. RN-D's Educare (online education) transcript indicated RN-D has completed one hour of dementia care education within the past 12 months. The transcript also indicated that RN-D had completed an additional hour of dementia care training on August 17, 2026 (after the start of the survey). The licensee's Weekly Work Schedule dated August 9, 2026, through August 22, 2026, indicated ULP-B was scheduled to work 80 hours in the two-week schedule and ULP-C was scheduled to work 96 hours over the two-week schedule. On August 19, 2026, at 2:40 p.m., licensed assisted living director (LALD)-A stated they were responsible for assigning the required online education modules to staff. LALD-A stated they were unaware that staff were missing required online education. LALD-A stated he "would have to check on that". The licensee's Staff Orientation and Education policy dated August 1, 2025, indicated all direct care staff and supervisors would receive training on dementia. No further information was provided.	01530		

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	37006	A. BUILDING: _____ B. WING _____	08/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01530	Continued From page 48 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 planning and care delivery. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed an in-person comprehensive nursing assessment prior to signing the assisted living contract/providing services for three of three residents (R1, R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	01610		

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	37006	A. BUILDING: _____ B. WING _____	08/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01610	Continued From page 49 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: R1 R1 was admitted on June 11, 2026, and began receiving assisted living services. R1's diagnoses included diabetes, high cholesterol, hypertension, and neuropathy. R1's Service Plan Waiver dated August 3, 2026, indicated R1's services included assistance with behavior management, making appointments, and vital sign monitoring. The service plan indicated that services were started on June 12, 2026. R1's admission assessment competed by registered nurse (RN)-F on June 15, 2026, indicating the initial assessment had been completed remotely three days after the start of services. R2 R2 was admitted to the licensee on June 10, 2026, and was discharged on July 19, 2026. R2's diagnoses included depression, alcohol use disorder, anxiety, diabetes, mood disorder with psychotic features, and schizophrenia. R2's unsigned Service Plan (Private) dated August 18, 2026, indicated R2's services included assistance with medication administration, safety checks, behavior management and observations for drug paraphernalia. R2's service plan indicated services were initiated on June 11 and 12, 2026.	01610		

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	37006	A. BUILDING: _____ B. WING _____	08/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESTEEM HOME HEALTH SERVICES	4024 IDAHO AVENUE CRYSTAL, MN 55427

(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
01610	Continued From page 50 R2's admission nursing assessment was completed remotely by registered nurse (RN)-F on June 11, 2026. R2's record lacked an in-person admission assessment. R3 R3 was admitted to the licensee on July 25, 2026, and discharged on August 7, 2026. R3's diagnoses included schizoaffective disorder and anxiety. R3's unsigned Service Plan (Private) dated August 18, 2026, indicated R3's services included medication administration. R3's service plan lacked identification of a date on which services were initiated. R3's admission assessment was completed remotely by RN-F on July 25, 2026. R3's record lacked an in-person admission assessment On August 10, 2025, at 12:05 p.m., the Crystal Polie Department filed a Vulnerable Adult Maltreatment Report with the Minesota Adult Abuse Reporting Center (MAARC), indicating police responded to the facility at 8:09 a.m., and 10:41 a.m., related to R3's aggressive behavior. R3 was removed from the facility and transferred to the hospital. The maltreatment report indicated the Crystal Police Department had responded over 10 times to calls from [licensee] to assist with R3's mental health needs, demonstrating that [licensee] was ill equipped to meet the needs of the resident they had admitted. On August 18, 2026, at 3:42 p.m., licensed assisted living director (LALD)-A stated R3's care was "beyond the capacity that we were able to care for him".	01610		

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	37006	A. BUILDING: _____ B. WING _____	08/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESTEEM HOME HEALTH SERVICES	4024 IDAHO AVENUE CRYSTAL, MN 55427

(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
01610	Continued From page 51 On August 19, 2026, at 2:45 p.m., RN-F stated they were currently out of state and did not know assessments were required to be completed in person. RN-F stated she had been out of state since her maternity leave started "about 7 weeks ago". On August 19, 2026, at 3:30 p.m., LALD-A confirmed by email that RN-F had started maternity leave on May 22, 2026. The licensee's undated Nursing Assessment and Reassessment of Residents policy indicated the RN would conduct in-person assessments. Minnesota Rule 4659.0140 Subpart 2.B (2) read "the nursing assessment or reassessment under item A must be conducted in person unless and exception under Minnesota Statutes, section 144G.70, subdivision 2, paragraph (b) applies. 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	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37006	A. BUILDING: _____ B. WING _____	08/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESTEEM HOME HEALTH SERVICES	4024 IDAHO AVENUE CRYSTAL, MN 55427

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01620	Continued From page 52 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 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.	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37006	A. BUILDING: _____ B. WING _____	08/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESTEEM HOME HEALTH SERVICES	4024 IDAHO AVENUE CRYSTAL, MN 55427

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01620	Continued From page 53 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted ongoing resident monitoring and reassessment to include a reassessment completed within 14 days after the initiation of 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 potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted on June 11, 2026, and began receiving assisted living services. R1's diagnoses included diabetes, high cholesterol, hypertension, and neuropathy. R1's Service Plan Waiver dated August 3, 2026, indicated R1's services included assistance with behavior management, making appointments, and vital sign monitoring. The service plan indicated that services were started on June 12, 2026. R1's admission assessment competed by registered nurse (RN)-F on June 15, 2026, indicating the initial assessment had been completed remotely three days after the start of services.	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37006	A. BUILDING: _____ B. WING _____	08/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESTEEM HOME HEALTH SERVICES	4024 IDAHO AVENUE CRYSTAL, MN 55427

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01620	Continued From page 54 On August 18, 2026, at 9:59 a.m., during a phone interview, registered nurse (RN)-F stated R1's initial assessment was completed remotely and R1's 14-day assessment was on paper. The surveyor requested a copy of R1's 14-day assessment. On August 18, 2026, at 1:00 p.m., the surveyor was assisting licensed assisted living director (LALD)-A with retrieving reports from Resdiex (online documentation system). The surveyor observed an instant message pop up on LALD-A's computer screen indicating a 14-day assessment could not be located at the office. On August 19, 2026, at 8:00 a.m., the surveyor received an email with a 14-day assessment for R1 dated June 25. The assessment had been handwritten and was signed and dated by RN-F. On August 19, 2026, at 2:26 p.m., RN-F stated they were currently out of state and had been away from Minnesota since her maternity leave started. RN-F stated she could not remember when her maternity leave started, but it was "about 7 weeks ago". RN-F stated she completed the 14-day assessment on R1, but could not remember if the assessments were completed while she was out of state. On August 19, 2026, at 3:30 p.m., LALD-A confirmed by email that RN-F had started maternity leave on May 22, 2026. R2 R2 was admitted to the licensee on June 10, 2026, and was discharged on July 19, 2026. R2's unsigned Service Plan (Private) dated August 18, 2026, indicated R2's services included	01620		

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01620	Continued From page 55 assistance with medication administration, safety checks, behavior management and observations for drug paraphernalia. R2's service plan indicated that services were initiated on June 11 and 12, 2026. R2's record lacked a nursing re-assessment completed within 14 days after initiation of services. On August 19, 2026, at 2:30 p.m., RN-F stated they did not remember completing a 14-day assessment for R2.. The licensee's undated Nursing Assessment and Reassessment of Residents policy indicated resident reassessment and monitoring would be conducted no more than 14 calendar days after initiating services. The policy also indicated The RN would conduct in-person assessments. Minnesota Rule 4659.0140 Subpart 2.B (2) read "the nursing assessment or reassessment under item A must be conducted in person unless and exception under Minnesota Statutes, section 144G.70, subdivision 2, paragraph (b) applies. 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	01640		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESTEEM HOME HEALTH SERVICES	4024 IDAHO AVENUE CRYSTAL, MN 55427

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01640	Continued From page 56 include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure revised service plans were authenticated by the resident or resident's representative, documenting agreement on the services to be provided for three of three residents (R1, R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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:	01640		

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	37006	A. BUILDING: _____ B. WING _____	08/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESTEEM HOME HEALTH SERVICES	4024 IDAHO AVENUE CRYSTAL, MN 55427

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01640	Continued From page 57 R1 R1 was admitted on June 11, 2026, and began receiving assisted living services. R1's unsigned Service Plan Waiver dated August 3, 2026, indicated R1's services included assistance with appointments, behavior management, and vital signs. R2 R2 was admitted to the licensee on June 10, 2026, and was discharged on July 19, 2026. R2's unsigned Service Plan (Private) dated August 18, 2026, indicated R2's services included assistance with medication administration, safety checks, behavior management,and observations for drug paraphernalia. R3 R3 was admitted to the licensee on July 25, 2026, and discharged on August 7, 2026. R3's unsigned Service Plan (Private) dated August 18, 2026, indicated R3's services included medication administration. R1, R2, and R3's service plans lacked authentication or signature from the residents or resident representatives indicating agreement on the services to be provided. On August 19, 2026, at 2:45 p.m., licensed assisted living director stated the service plans for R1, R2, and R3 were not signed. LALD-A stated R1, R2, and R3 had not completed their admission paperwork, and it was "very difficult" to get the service plans signed. The licensee's undated Service Plan policy	01640		

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ESTEEM HOME HEALTH SERVICES	4024 IDAHO AVENUE CRYSTAL, MN 55427

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01640	Continued From page 58 indicated that service plans and any revisions would include signature or other authentication by the licensee and by the resident or resident's representative documenting agreement on the services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned	01650		

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ESTEEM HOME HEALTH SERVICES	4024 IDAHO AVENUE CRYSTAL, MN 55427

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01650	Continued From page 59 consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the resident service plan included the required content for three of three residents (R1, R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R1 On August 18, 2026, at 8:05 a.m., the surveyor observed ULP-B monitoring vital signs and administering medications to R1. On August 19, 2026, at 9:22 a.m., the surveyor observed ULP-C monitoring vital signs and administering medications to R1. R1 was admitted on June 11, 2026, and began receiving assisted living services. R1's unsigned Service Plan Waiver dated August 3, 2026, indicated R1's services included assistance with appointments, behavior management, and vital signs.	01650		

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	37006	A. BUILDING: _____ B. WING _____	08/20/2026

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01650	Continued From page 60 R1's Service Plan Waiver lacked the following required content: -a description of all services provided (medication administration); and -the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant change in condition. R2 R2 was admitted to the licensee on June 10, 2026, and was discharged on July 19, 2026. R2's unsigned Service Plan (Private) dated August 18, 2026, indicated R2's services included assistance with medication administration, safety checks, behavior management, and observations for drug paraphernalia. R2's service Plan (Private) lacked the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant change in condition. R3 R3 was admitted to the licensee on July 25, 2026, and discharged on August 7, 2026. R3's unsigned Service Plan (Private) dated August 18, 2026, indicated R3's services included medication administration. R3's service Plan (Private) lacked the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant change in condition. On August 19, 2026, at 2:30 p.m., licensed assisted living director (LALD)-A stated they were	01650		

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01650	Continued From page 61 unaware the service plans were missing required information. LALD-A stated they did not have emergency contact information for R1, R2, or R3. The licensee's undated Service Plan policy indicated service plans would include a description of services to be provided. The policy also indicated the service plan would include the name and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification and information as to who has authority to sign for the resident in an emergency. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01700 SS=F	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues.	01700		

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	37006	A. BUILDING: _____ B. WING _____	08/20/2026

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01700	Continued From page 62 (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. 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 face-to-face medication management assessment for three of three residents (R1, R2, R3) which included all content prior to providing medication management services for two of three 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 potential to affect a large portion or all of the residents). The findings include: R1 On August 18, 2026, at 8:05 a.m., the surveyor observed ULP-B monitoring vital signs and administering medications to R1.	01700		

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01700	Continued From page 63 On August 19, 2026, at 9:22 a.m., the surveyor observed ULP-C monitoring vital signs and administering medications to R1. R1 was admitted on June 11, 2026, and began receiving assisted living services. R1's unsigned Service Plan Waiver dated August 3, 2026, indicated R1's services included assistance with appointments, behavior management, and vital signs. R1's Medication Administration Record dated August (no year identified) indicated medications that had been administered to R1 included: -gabapentin 800 milligrams (mg) three times daily (for neuropathy); -lisinopril 2.5 mg daily (for blood pressure); -metformin 1000 mg twice daily (for diabetes); -metoprolol extended release (ER) succinate 25 mg daily (for blood pressure); -quetiapine 300 mg at bedtime (for sleep disturbances); and -simvastatin 40 mg at bedtime (for high cholesterol). R1's medication assessment dated June 15, 2026, indicated the assessment was completed remotely by RN-F and lacked the following required content: -identification and review of all medications the resident is known to be taking including indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues; and -interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the	01700		

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	37006	A. BUILDING: _____ B. WING _____	08/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01700	Continued From page 64 resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. R2 R2 was admitted to the licensee on June 10, 2026, and was discharged on July 19, 2026. R2's unsigned Service Plan (Private) dated August 18, 2026, indicated R2's services included assistance with medication administration. R2's Medication Admin Summary dated July 2026, indicated the following medications had been administered to R2: -metformin 1000 mg daily (for diabetes); -naltrexone 50 mg daily (for substance abuse disorder); -olanzapine 10 mg daily (for mental health disorder); and -vitamin D3 25 micrograms (mcg) (for vitamin deficiency). R2's medication assessment dated June 11, 2026, indicated the assessment was completed remotely by RN-F and lacked the following required content: -identification and review of all medications the resident is known to be taking including indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues; and -interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of	01700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37006	A. BUILDING: _____ B. WING _____	08/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESTEEM HOME HEALTH SERVICES	4024 IDAHO AVENUE CRYSTAL, MN 55427

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01700	Continued From page 65 medications. R3 R3 was admitted to the licensee on July 25, 2026, and discharged on August 7, 2026. R3's unsigned Service Plan (Private) dated August 18, 2026, indicated R3's services included medication administration. R3's Med Admin Summary dated August 2026, indicated aripiprazole 10 mg daily had been administered to R3 on August 3 and 4, 2026. R3's medication assessment dated July 25, 2026, indicated the assessment was completed remotely by RN-F. On August 18, 2026, at 10:05 a.m., RN-F stated she had completed the medication management assessments for R1, R2, and R3. RN-F stated she was not sure what needed to be included in the medication management assessments. On August 19, 2026, at 2:31 p.m., RN-F stated she was unaware that medication management assessments were required to be completed face-to-face. The licensee's undated Medication Management Services policy indicated the RN would be responsible for monitoring and evaluating medication use and reassessing resident's medication management services, including signs and symptoms of side effects, allergic reactions, or dose intolerance. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ESTEEM HOME HEALTH SERVICES	4024 IDAHO AVENUE CRYSTAL, MN 55427

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01700	Continued From page 66 days	01700		
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 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	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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ESTEEM HOME HEALTH SERVICES	4024 IDAHO AVENUE CRYSTAL, MN 55427

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01730	Continued From page 67 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 an individualized medication management record with the required content for two of three 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 potential to affect a large portion or all of the residents). The findings include: R1 On August 18, 2026, at 8:05 a.m., the surveyor observed ULP-B monitoring vital signs and administering medications to R1. On August 19, 2026, at 9:22 a.m., the surveyor observed ULP-C monitoring vital signs and administering medications to R1. R1 was admitted on June 11, 2026, and began	01730		

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	37006	A. BUILDING: _____ B. WING _____	08/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESTEEM HOME HEALTH SERVICES	4024 IDAHO AVENUE CRYSTAL, MN 55427

(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
01730	Continued From page 68 receiving assisted living services. R1's unsigned Service Plan Waiver dated August 3, 2026, indicated R1's services included assistance with appointments, behavior management, and vital signs. R1's Medication Administration Record dated August (no year identified) indicated medications that had been administered to R1 included -gabapentin 800 milligrams (mg) three times daily (for neuropathy); -lisinopril 2.5 mg daily (for blood pressure); -metformin 1000 mg twice daily (for diabetes); -metoprolol extended release (ER) succinate 25 mg daily (for blood pressure); -quetiapine 300 mg at bedtime (for sleep disturbances); and -simvastatin 40 mg at bedtime (for high cholesterol). R1's record lacked a medication management plan, developed by a registered nurse (RN), that included the following required content: -a statement describing the medication management services that would be provided; -a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; -documentation of specific resident instructions relating to the administration of medications; -identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; -identification of medication management tasks that may be delegated to unlicensed personnel; -procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37006	A. BUILDING: _____ B. WING _____	08/20/2026

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01730	Continued From page 69 services; and -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. R2 R2 was admitted to the licensee on June 10, 2026, and was discharged on July 19, 2026. R2's unsigned Service Plan (Private) dated August 18, 2026, indicated R2's services included assistance with medication administration. R2's Medication Admin Summary dated July 2026, indicated the following medications had been administered to R2: -metformin 1000 mg daily (for diabetes); -naltrexone 50 mg daily (for substance abuse disorder); -olanzapine 10 mg daily (for mental health disorder); and -vitamin D3 25 micrograms (mcg) (for vitamin deficiency). R2's Individualized Medication Management Plan dated June 11, 2026, lacked the following required content: -a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; -documentation of specific resident instructions relating to the administration of medications; -identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; -identification of medication management tasks	01730		

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	37006	A. BUILDING: _____ B. WING _____	08/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESTEEM HOME HEALTH SERVICES	4024 IDAHO AVENUE CRYSTAL, MN 55427

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01730	Continued From page 70 that may be delegated to unlicensed personnel; -procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and -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. The surveyor requested a medication management plan for R1 on August 17, 2026, at 12:51 p.m., and August 18, 2026, at 9:13 a.m., and 3:54 p.m., respectively. The requested document was not provided during the survey. On August 19, 2026, at 2:34 p.m., RN-F stated she was not aware the medication management plans were incomplete. RN-F stated she was unsure of all the content required in medication management plans. The licensee's undated Medication Management Services policy indicated the RN would develop an individualized medication management plan for each resident receiving any type of medication management services, consistent with current practice standards and guidelines and would develop specific procedures for medication management services that staff would provide. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37006	A. BUILDING: _____ B. WING _____	08/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESTEEM HOME HEALTH SERVICES	4024 IDAHO AVENUE CRYSTAL, MN 55427

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01760	Continued From page 71	01760		
01760 SS=F	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 license failed to ensure medication administration was accurately documented and transcribed for three of three residents (R1, R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R1 On August 18, 2026, at 8:05 a.m., the surveyor	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37006	A. BUILDING: _____ B. WING _____	08/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESTEEM HOME HEALTH SERVICES	4024 IDAHO AVENUE CRYSTAL, MN 55427

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01760	Continued From page 72 observed ULP-B monitoring vital signs and administering medications to R1. On August 19, 2026, at 9:22 a.m., the surveyor observed ULP-C monitoring vital signs and administering medications to R1. R1 was admitted on June 11, 2026, and began receiving assisted living services. R1's unsigned Service Plan Waiver dated August 3, 2026, indicated R1's services included assistance with appointments, behavior management, and vital signs. R1's record included Medication Administration Records (MAR) dated June (no year identified), July (no year identified) and August (no year identified) indicating the following medications that had been administered to R1: -gabapentin 800 milligrams (mg) three times daily (for neuropathy); -lisinopril 2.5 mg daily (for blood pressure); -metformin 1000 mg twice daily (for diabetes); -metoprolol extended release (ER) succinate 25 mg daily (for blood pressure); -quetiapine 300 mg at bedtime (for sleep disturbances); and -simvastatin 40 mg at bedtime (for high cholesterol). R1's MARs lacked signatures and titles of the people who administered the medications. R2 R2 was admitted to the licensee on June 10, 2026, and was discharged on July 19, 2026. R2's unsigned Service Plan (Private) dated August 18, 2026, indicated R2's services included	01760		

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	37006	A. BUILDING: _____ B. WING _____	08/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESTEEM HOME HEALTH SERVICES	4024 IDAHO AVENUE CRYSTAL, MN 55427

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01760	Continued From page 73 assistance with medication administration. R2's Medication Admin Summary dated July 2026, indicated the following medications had been administered to R2: -metformin 1000 mg daily (for diabetes); -naltrexone 50 mg daily (for substance abuse disorder); -olanzapine 10 mg daily (for mental health disorder); and -vitamin D3 25 micrograms (mcg) (for vitamin deficiency). R2's medication record lacked documentation that medications had been administered on the following dates: -metformin 1000 mg on July 2, 4, 5, 6, 8, 10, 11, 12, 13, 14, 16, and 17, 2026; -naltrexone 50 mg on July 2, 4, 5, 6, 8, 10, 11, 12, 13, 14, 16, and 17, 2026; -olanzapine 10 mg on July 2, 4, 5, 6, 8, 10, 11, 12, 13, 14, 16, and 17, 2026; and -vitamin D3 on July 2, 4, 5, 6, 8, 10, 11, 12, 13, 14, 16, and 17, 2026. R3 R3 was admitted to the licensee on July 25, 2026, and discharged on August 7, 2026. R3's unsigned Service Plan (Private) dated August 18, 2026, indicated R3's services included medication administration. R3's record included Med Admin Summaries dated July 2026, and August 2026, indicating the following medications were being administered to R3: -aripiprazole 10 mg daily (for mental health disorder); and -gabapentin 200 mg twice daily (for anxiety,	01760		

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	37006	A. BUILDING: _____ B. WING _____	08/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01760	Continued From page 74 restlessness, agitation). R3's medication administration records lacked documentation that the following medication sere administered to R3: -aripiprazole 10 mg on July 26, 29, 30, 30, 2026, and August 1 and 2, 2026. -gabapentin 200 mg at 10:00 a.m., on July 26, 27, 28, 29, 30, 31, 2026, and August 1 and 2, 2026; and - gabapentin 200 mg at 10:00 p.m., on July 26, 27, 28, 29, 30, 31, 2026, and August 1 and 2, 2026. On August 19, 2026, at 2:30 p.m., registered nurse (RN)-F stated they were unaware that medications had not been given or documented as required. The licensee's undated Documentation of Medication Administration policy indicated documentation would include: -the signature and title of the person administering medication; -the reason why medication administration was not completed as prescribed; and -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. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01820 SS=F	144G.71 Subd. 13 Prescriptions There must be a current written or electronically	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37006	A. BUILDING: _____ B. WING _____	08/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESTEEM HOME HEALTH SERVICES	4024 IDAHO AVENUE CRYSTAL, MN 55427

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01820	Continued From page 75 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 there were current written or electronically recorded prescriptions as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility was managing for three of three residents (R1, R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R1 On August 18, 2026, at 8:05 a.m., the surveyor observed ULP-B monitoring vital signs and administering medications to R1. On August 19, 2026, at 9:22 a.m., the surveyor observed ULP-C monitoring vital signs and administering medications to R1. R1 was admitted on June 11, 2026, and began receiving assisted living services. R1's unsigned Service Plan Waiver dated August	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37006	A. BUILDING: _____ B. WING _____	08/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESTEEM HOME HEALTH SERVICES	4024 IDAHO AVENUE CRYSTAL, MN 55427

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01820	Continued From page 76 3, 2026, indicated R1's services included assistance with appointments, behavior management, and vital signs. R1's record included Medication Administration Records (MAR) dated June (no year identified), July (no year identified) and August (no year identified) indicating the following medications that had been administered to R1: -gabapentin 800 milligrams (mg) three times daily (for neuropathy); -lisinopril 2.5 mg daily (for blood pressure); -metformin 1000 mg twice daily (for diabetes); -metoprolol extended release (ER) succinate 25 mg daily (for blood pressure); -quetiapine 300 mg at bedtime (for sleep disturbances); and -simvastatin 40 mg at bedtime (for high cholesterol). R1's record lacked a written or electronically signed prescription for all medications administered. R2 R2 was admitted to the licensee on June 10, 2026, and was discharged on July 19, 2026. R2's unsigned Service Plan (Private) dated August 18, 2026, indicated R2's services included assistance with medication administration. R2's Medication Admin Summary dated July 2026, indicated the following medications had been administered to R2: -metformin 1000 mg daily (for diabetes); -naltrexone 50 mg daily (for substance abuse disorder); -olanzapine 10 mg daily (for mental health disorder); and	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37006	A. BUILDING: _____ B. WING _____	08/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESTEEM HOME HEALTH SERVICES	4024 IDAHO AVENUE CRYSTAL, MN 55427

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01820	Continued From page 77 -vitamin D3 25 micrograms (mcg) (for vitamin deficiency). R2's record lacked a written or electronically signed prescription for all medications administered. R3 R3 was admitted to the licensee on July 25, 2026, and discharged on August 7, 2026. R3's unsigned Service Plan (Private) dated August 18, 2026, indicated R3's services included medication administration. R3's record included Med Admin Summaries dated July 2026, and August 2026, indicating the following medications were being administered to R3: -aripiprazole 10 mg daily (for mental health disorder); and -gabapentin 200 mg twice daily (for anxiety, restlessness, agitation). R3's record included a Visit Summary dated July 22, 2026, listing medications R3 was to be taking. The visit summary lacked a written or electronic signature of the provider. On August 18, 2026, at 10:30 a.m., licensed assisted living director (LALD)-A stated they did not know who to call for R2's orders. LALD-A stated they did not know who was R2's physician. On August 19, 2026, at 2:34 p.m., LALD-A stated he was unaware that R3's record lacked signed prescriber orders. LALD-A stated, "I can do it now". On August 19, 2026, at 5:09 p.m., the surveyor	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37006	A. BUILDING: _____ B. WING _____	08/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESTEEM HOME HEALTH SERVICES	4024 IDAHO AVENUE CRYSTAL, MN 55427

(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
01820	Continued From page 78 received an email from LALD-A indicating they had faxed a request to Fairview for prescriber orders for R1 and have not yet been able to obtain the orders. The licensee's undated Medication Management Services policy indicated the facility would require a prescription for all medications that the facility would manage for their residents, including over-the-counter medications and dietary supplements. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37006	A. BUILDING: _____ B. WING _____	08/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESTEEM HOME HEALTH SERVICES	4024 IDAHO AVENUE CRYSTAL, MN 55427

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01910	Continued From page 79 individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document the disposition of the medications in the resident's record, for one of two discharged 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). The findings include: R2 was admitted to the licensee on June 10, 2026, and was discharged on July 19, 2026. R2's unsigned Service Plan (Private) dated August 18, 2026, indicated R2's services included assistance with medication administration. R2's Resident Notes dated July 18, 2026, at 9:50 p.m., indicated R2 had been transferred to the hospital. R2's record lacked documentation of mediation disposition to include the following required information: -medication name; -strength; -prescription number as applicable; -quantity of medication; -to whom the medications were given;	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37006	A. BUILDING: _____ B. WING _____	08/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESTEEM HOME HEALTH SERVICES	4024 IDAHO AVENUE CRYSTAL, MN 55427

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01910	Continued From page 80 -date of disposition; and -names of staff and other individuals involved in the disposition. On August 18, 2026, at 10:34 a.m., licensed assisted living director (LALD)-A stated R2 "was not really a resident" of the facility since the admission paperwork had not been completed. On August 19, 2026, at 2:45 p.m., registered nurse (RN)-F stated they were unaware that R2's record lacked documentation of medication disposition. The licensee's undated Medication Disposition or Disposal policy indicated the following: -discontinued or unused drugs would be destroyed within one month or less of the time they are discontinued or the day of death or discharge of the resident; -prescription drugs managed and secured by the licensee that are left at the facility after the death or termination of services for a resident for whom the drug was prescribed, would be destroyed by the registered nurse or pharmacist with one other person as a witness; and -staff would document the disposition or disposal of medications in the client's record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
02240 SS=A	144G.90 Subdivision 1 Assisted living bill of rights; notification (a) An assisted living facility must provide the resident a written notice of the rights under	02240		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37006	A. BUILDING: _____ B. WING _____	08/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESTEEM HOME HEALTH SERVICES	4024 IDAHO AVENUE CRYSTAL, MN 55427

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02240	Continued From page 81 section 144G.91 before the initiation of services to that resident. The facility shall make all reasonable efforts to provide notice of the rights to the resident in a language the resident can understand. (b) In addition to the text of the assisted living bill of rights in section 144G.91, the notice shall also contain the following statement describing how to file a complaint or report suspected abuse: "If you want to report suspected abuse, neglect, or financial exploitation, you may contact the Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about the facility or person providing your services, you may contact the Office of Health Facility Complaints, Minnesota Department of Health. If you would like to request advocacy services, you may contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities." (c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, email address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities. The statement must include the facility's name, address, email, telephone number, and name or title of the person at the facility to whom problems or complaints may be directed. It must also include a statement that the facility will not retaliate because of a complaint. (d) A facility must obtain written acknowledgment from the resident of the resident's receipt of the assisted living bill of rights or shall document why an acknowledgment cannot be obtained.	02240		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37006	A. BUILDING: _____ B. WING _____	08/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESTEEM HOME HEALTH SERVICES	4024 IDAHO AVENUE CRYSTAL, MN 55427

(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
02240	Continued From page 82 Acknowledgment of receipt shall be retained in the resident's record. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to obtain written acknowledgement if a resident's receipt of the assisted living bill of rights and failed to document why an acknowledgement could not be obtained for one of three residents (R1). 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 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 on June 11, 2026, and began receiving assisted living services. R1's unsigned Service Plan Waiver dated August 3, 2026, indicated R1's services included assistance with appointments, behavior management, and vital signs. R1's record lacked written acknowledgement of receipt of the assisted living bill of rights or documentation why acknowledgement could not be obtained. On August 17, 2026, at 11:32 a.m., licensed assisted living director (LALD)-A stated R1 did not have a signed acknowledgement of receiving a UDALSA in her records. LALD-A stated they had given the information to R1 who refused to sign	02240		

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	37006	A. BUILDING: _____ B. WING _____	08/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESTEEM HOME HEALTH SERVICES	4024 IDAHO AVENUE CRYSTAL, MN 55427

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02240	Continued From page 83 and had given the information to her case manager. The licensee's undated Assisted living Bill of Rights policy indicated each resident or resident representative would be provided with a written notice of their rights prior to initiation of services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02240		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure care and services were provided according to acceptable health care and medical or nursing standards for one of one resident (R1) with a consumer bed rail. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at 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).	02310	During the course of the survey, the licensee failed to take action to mitigate the imminent risk.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37006	A. BUILDING: _____ B. WING _____	08/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02310	Continued From page 84 The findings include: On August 18, 2026, at 9:00 a.m., the surveyor observed a consumer bed rail on the left side of R1's bed. The bed rail was shaped like a question mark, approximately one foot wide at the top. The bed rail was secured with 2 bolts to a board that was placed between the mattress and the box spring of the bed. An organizer pouch was covering the bed rail. R1's Service Plan Waiver dated August 3, 2026, indicated R1 received services including assistance with assistance with vital signs, appointments, and behavior management. R1's nursing assessment completed on June 15, 2026, indicated R1 was independent and did not require assistance with ambulation, bed mobility, or transfers. R1's 14 Day Nursing Assessment completed on June 25, 2026, lacked identification of the type or location of the bed rail. The assessment indicated that "five entrapment zones were assessed and met the guidelines" (the seven zones of entrapment identified by the Food and Drug Administration (FDA)'s guidelines apply only to hospital bed rails, not a consumer bed rail as was on R1's bed). The assessment indicated the bed rail was used for positioning and support. R1's record lacked the following documentation: -correct identification of and location of a consumer bed rail; -condition and description of the bed rail; -risk vs. benefits discussion; -installation and use according to manufacturer's guidelines;	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37006	A. BUILDING: _____ B. WING _____	08/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESTEEM HOME HEALTH SERVICES	4024 IDAHO AVENUE CRYSTAL, MN 55427

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02310	Continued From page 85 -physical inspection of the bed rail and mattress for areas of entrapment, stability, and correct installation; and -documentation of review of Consumer Product Safety Commission (CPSC) website for recalled bed rails. On August 18, 2026, at 10:16 a.m., registered nurse (RN)-F stated the bed and bed rail "came with the resident" and she evaluated R1's ability to get in and out of bed with the bed rail and she "measured the rails". RN-F stated she did not know where she documented the information and that "it should be in the assessment". On August 19, 2026, at 8:03 a.m., licensed assisted living director (LALD)-A provided the surveyor with manufacturer's guideline for the bed rail. The models indicated on the manufacturer's guideline did not match the bed rail on R1's bed. On August 19, 2026, at 12:30 p.m., LALD-A stated they were unaware the manufacturer's guideline did not match the actual bed rail on R1's bed. LALD-A stated they would look at the bed rail when they arrived at the facility. LALD-A stated they had not checked the CPSC for a recall on the bed rail. LALD-A stated the bed and bed rail had been used by a former resident and R1 "didn't really need it" and "it was not prescribed for her". The FDA's, A Guide to Bed Safety, revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of	02310		

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	37006	A. BUILDING: _____ B. WING _____	08/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02310	Continued From page 86 bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The Minnesota Department of Health's (MDH) Assisted Living: Resources and FAQ's website updated April 17, 2026, read under Bed Rails, documentation about a resident's bed rails includes, but is not limited to: -an assessment was completed; -the bed rails were determined to not act as a restraint; -the portable bed rails were installed and maintained according to the manufacturer's guidelines; and -the risk vs. benefits were discussed and documented with the resident/responsible party. The licensee's undated Use of Siderails policy indicated the following actions would be taken when a resident is utilizing side rails: -the RN would educate the resident/representative about the risks related to side rails; -the RN will assess whether the siderails meet FDA standards; and -documentation on who received the education on the safe use of side rails. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	02310		

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

ESTEEM HOME HEALTH SERVICES LL
4024 IDAHO AVENUE
Crystal, MN 55427
Hennepin County
Parcel:

Phone:

License Info

License: HFID 37006

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

Inspection Info

Report Number: F8041261102
Inspection Type: Full - Single
Date: 8/18/2026 Time: 12:00 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 3
Total Priority 2 Orders: 4
Total Priority 3 Orders: 3
Delivery: Emailed

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: CERTIFIED FOOD PROECTION MANAGER CERTIFICATE EXPIRED 8/8/24. COURSE INFORMATION AND APPLICATION SENT WITH REPORT.
Comply By: 8/18/2026 Originally Issued On: 8/18/2026

! **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: UNPASTEURIZED SHELL EGGS STORED ON SHELF IN REFRIGERATOR ABOVE READY TO EAT FOODS. SHELL EGGS WERE MOVED TO THE BOTTOM DRAWER IN COOLER DURING INSPECTION TO PREVENT CROSS CONTAMINATION.
Comply By: 8/18/2026 Originally Issued On: 8/18/2026

New Order: 3-500C Microbial Control: date marking
3-501.17B *Priority Level: Priority 2 CFP#: 23*
MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.
COMMENT: OPENED PACKAGES OF DELI MEAT, HOT DOGS, BRATS AND CUT MELON NOT DATE MARKED. DATE MARK AS STATED ABOVE TO ENSURE TCS FOODS ARE USED WITHIN 7 DAYS AFTER OPENING. ITEMS WERE DATE MARKED DURING INSPECTION.
Comply By: 8/18/2026 Originally Issued On: 8/18/2026

New Order: 4-300 Equipment Numbers and Capacities
4-302.12B *Priority Level: Priority 2 CFP#: 36*
MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.
COMMENT: ISSUED 7/9/24 (REPEAT): NO THERMOMETER PROVIDED. ADVISED STAFF TO PROVIDE AN MAINTAIN A THERMOMETER WITHIN THE FACILITY.
Comply By: 8/18/2026 Originally Issued On: 8/18/2026

New Order: 4-300 Equipment Numbers and Capacities
4-302.13B *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.
COMMENT: FACILITY DOES NOT HAVE A TEMPERATURE INDICATOR TO MEASURE THE UTENSIL SURFACE TEMPRATURE INSIDE THE DISH MACHINE. THERMAL STRIP PROVIDED FOR TESTING DURING INSPECTION.
Comply By: 9/1/2026 Originally Issued On: 8/18/2026

New Order: 4-600 Cleaning Equipment and Utensils
4-601.11C *Priority Level: Priority 3 CFP#: 49*
MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.
COMMENT: OBSERVED RODENT DROPPINGS IN THE KITCHEN CUPBOARDS, DRAWERS AND PANTRY. THOROUGHLY CLEAN AND DISINFECT SURFACES.
Comply By: 8/18/2026 Originally Issued On: 8/18/2026

! **New Order: 4-700 Sanitizing Equipment and Utensils**
4-702.11 *Priority Level: Priority 1 CFP#: 16*
MN Rule 4626.0900 Sanitize utensils and food contact surfaces of equipment before use, after cleaning.
COMMENT: FACILITY IS WASHING AND RINSING DISHES IN THE TWO BASIN SINK. FACILITY MUST USE THE DISH MACHINE FOR ALL WAREWASHING TO ENSURE DISHES ARE PROPERLY SANITIZED WHEN THE DISHWASHER IS REPAIRED. ALL DISHES AND UTENSILS IN CABINETS/DRAWERS MUST BE WASHED, RINSED AND SANITIZED.
Comply By: 8/18/2026 Originally Issued On: 8/18/2026

! **New Order: 4-700 Sanitizing Equipment and Utensils**
4-703.11B *Priority Level: Priority 1 CFP#: 16*
MN Rule 4626.0905B Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.
COMMENT: DISH MACHINE ACHIEVED A UTENSIL SURFACE TEMPERATURE OF LESS THAN 150F. USE ALTERNATIVE MEASURES TO SANITIZE UNTIL DISHWASHER IS REPAIRED. FACT SHEET SENT WITH REPORT. FACILITY WILL PURCHASE UNSCENTED BLEACH FOR SANITIZING.
Comply By: 8/18/2026 Originally Issued On: 8/18/2026

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control
6-501.111C *Priority Level: Priority 2 CFP#: 38*
MN Rule 4626.1565C Use approved trapping devices or other means of pest control when pests are found.
COMMENT: OBSERVED RODENT DROPPINGS IN THE KITCHEN CABINETS, DRAWERS AND PANTRY. WORK WITH PEST CONTROL COMPANY TO ELIMINATE PESTS.
Comply By: 8/18/2026 Originally Issued On: 8/18/2026

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control
6-501.12A *Priority Level: Priority 3 CFP#: 55*
MN Rule 4626.1520A Clean and maintain all physical facilities clean.
COMMENT: A BUILD-UP OF GREASE OBSERVED ON THE WALL BEHIND THE STOVE.
Comply By: 8/25/2026 Originally Issued On: 8/18/2026

Food & Beverage General Comment

Inspection was completed with Edwin Jenkins and Emmanuel Whegar. Michelle Winters was the HRD nurse evaluator.

Facility has a residential kitchen. Food must be prepared for same day service only. Kitchen has a smooth ceiling, wood flooring, wood cabinets with a hollow base and a laminate countertop.Food is prepared on site by staff. There was one resident at time of inspection.

Discussed the following:
- Employee illness policy and logging requirements
- Reporting foodborne illness complaints to the health dept.
- Handwashing
- Date marking
- Glove-use and bare hand contact
- Proper food storage
-Vomit clean-up procedures
- Restrictions concerning serving a highly susceptible population

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 F8041261102 from 8/18/2026

Emmanuel Whegar

Sarah Conboy,
Public Health Sanitarian Supervisor
651-201-3984
sarah.conboy@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

ESTEEM HOME HEALTH SERVICES LL
Crystal
County/Group: Hennepin County

Inspection Info

Report Number: F8041261102
Inspection Type: Full
Date: 8/18/2026
Time: 12:00 PM

Food Temperature: Product/Item/Unit: hot dog**; Temperature Process:** Cold-Holding
Location: Refrigerator at 40 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: cut melon**; Temperature Process:** Cold-Holding
Location: Refrigerator at 40 Degrees F.
Comment:
Violation Issued?: No

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

Sanitizer Observations/Recordings

Establishment Info

ESTEEM HOME HEALTH SERVICES LL
Crystal
County/Group: Hennepin County

Inspection Info

Report Number: F8041261102
Inspection Type: Full
Date: 8/18/2026
Time: 12:00 PM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Kitchen **Less Than** 150 Degrees F.
Comment:
Violation Issued?: No