Electronically Delivered

August 24, 2026

Licensee
Heritage Court Assisted Living
110 South Henderson Street
Houston, MN 55943

RE: Project Number(s) SL20339016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 22, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

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

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00

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

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

The correction order documentation should include the following:

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

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

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

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

factor.

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

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers.

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,

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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20339	A. BUILDING: _____ B. WING _____	07/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE COURT ASSISTED LIVING	110 SOUTH HENDERSON STREET HOUSTON, MN 55943

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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: SL20339016-0 On July 20, 2026, through July 22, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 18 resident(s); 17 receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a 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	0 480		

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 July 22, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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0 480	Continued From page 3 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the required information related to the contact information for the state and applicable Office of Ombudsman for Mental Health and Developmental Disabilities. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 550		

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0 550	Continued From page 4 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: On July 20, 2026, at 1:05 p.m., the surveyor observed the facility's postings. These postings included the required contact information for the state and applicable regional Office of Ombudsman for Long-Term Care; however, it lacked the required contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities. On July 20, 2026, at 1:05 p.m., licensed assisted living director (LALD)-A stated she was not aware of the requirement for the Ombudsman for Mental Health and Developmental Disabilities posting, found the appropriate contact information and posted it during the time of survey. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be	0 630		

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0 630	Continued From page 5 taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for two of two residents (R3, R7). 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: R3 R3 began receiving assisted living (ALF) services from the licensee on December 8, 2025, with diagnoses including atrial fibrillation, chronic kidney disease (stage 3), type 2 diabetes, anxiety and depression. R3's Service Plan dated April 13, 2026, indicated he received services including medication management/administration, blood sugar monitoring, assistance with compression stockings and showers, and safety checks. R3's Service Plan lacked the service of daily weights. On July 21, 2026, at 7:25 a.m. the surveyor	0 630		

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0 630	Continued From page 6 observed unlicensed personnel (ULP)-E set up and administer R3's morning medications and obtained R3's weight. R3's IAPP dated July 3, 2026, indicated R3 was not at risk to abuse others, including other vulnerable adults, and did not have a history of suicide or suicidal ideation; however, R3's IAPP lacked the required content to include his risk for abuse by others including other vulnerable adults, and lacked interventions to minimize the risk for abuse. R7 R7 began receiving ALF services from the licensee on August 18, 2025, with diagnoses including mild cognitive impairment and type 2 diabetes. R7's Service Plan dated April 29, 2026, indicated she received services including assistance with showers, toileting, medication management/administration, and blood sugar monitoring. On July 21, 2026, at 11:15 a.m., the surveyor observed ULP-D check R7's blood sugar and assisted her to the bathroom. R7's IAPP dated April 29, 2026, indicated she was not at risk of abusing others including other vulnerable adults, was at risk for self-neglect; however, R7's IAPP lacked the required content to include her risk for abuse by others including other vulnerable adults, and lacked interventions to minimize the risk for abuse. The licensee failed to indicate R3 and R7's risk for abuse by others including other vulnerable	0 630		

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0 630	Continued From page 7 adults; furthermore, the licensee failed to include additional interventions to mitigate their risk for abuse. On July 22, 2026, at 11:30 a.m., clinical nurse supervisor (CNS)-B stated she was not aware the required content needed to include the residents' risk for abuse from others, including other vulnerable adults. She further stated all residents residing in the facility were considered vulnerable adults and were at risk of abuse and neglect. The licensee's Individual Abuse Prevention Plan policy dated April 27, 2022, indicated the individual abuse prevention plan will include an individualized review or assessment of the resident's susceptibility to be abused by another individual, including other vulnerable adults. Specific measures to minimize the risk of abuse to that person and other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota	0 775		

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0 775	Continued From page 8 Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated July 21, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction	01290		

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01290	Continued From page 9 does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure three of 27 employees (unlicensed personnel (ULP)-F, ULP-G, ULP-H) were affiliated with the assisted living license as required. This had the potential to affect the licensee's 18 residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On July 21, 2026, at 9:40 a.m., licensed assisted living director (LALD)-A provided the surveyor with the licensee's NETStudy roster dated July 21, 2026. ULP-F ULP-F was hired on June 2, 2026, to provide direct care services to the licensee's residents. The licensee's NETStudy roster dated July 21, 2026, indicated ULP-F was affiliated with the licensee's health facility identification (HFID-20339) on July 21, 2026, (during survey) and had a background study previously affiliated with the licensee's "sister" facility (HFID-32112) on August 27, 2025.	01290		

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01290	Continued From page 10 ULP-G ULP-G was hired on March 8, 2016, to provide direct care services to the licensee's residents. The licensee's NETStudy roster dated July 21, 2026, indicated ULP-G's background study was affiliated with the licensee's HFID 20339 on July 21, 2026, (during survey) and had a cleared background study previously completed on August 27, 2025, with the licensee's sister facility. ULP-G's record lacked evidence the licensee affiliated a background study for their assisted living facility. ULP-H ULP-H was hired on June 2, 2026, to provide direct care services to the licensee's residents. The licensee's NETStudy roster dated July 21, 2026, indicated ULP-H's background clearance was affiliated with the licensee's HFID 20339 on July 21, 2026 (during survey) and had a cleared background study completed on May 31, 2022, with the licensee's sister facility. ULP-H's record lacked evidence that the licensee affiliated a background study for their assisted living facility On July 21, 2026, at 10:10 a.m., licensed assisted living director (LALD)-A stated the licensee had affiliated with the above indicated employees that same day as they had noted the employees were only affiliated with the licensee's sister facility, a skilled nursing facility (SNF). The licensee's Background Check Policy dated April 27, 2022, indicated all employees must pass	01290		

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01290	Continued From page 11 a background study and all contractors or volunteers with direct resident contact are required to have a background study. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications did not exceed their expiration date for two of 17 residents (R4, R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On July 21, 2026, at 7:50 a.m., the surveyor and	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20339	A. BUILDING: _____ B. WING _____	07/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE COURT ASSISTED LIVING	110 SOUTH HENDERSON STREET HOUSTON, MN 55943

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01890	Continued From page 12 unlicensed personnel (ULP)-D reviewed the contents of the licensee's medication cart. The medication cart included the following expired medications: R4 -MiraLAX 17 grams (gm), give 17 gm mixed with 4-6 ounces of fluid as directed, as needed for constipation-the opened bottle indicated an expiration date of March 27, 2024. R6 -loperamide 2 milligrams (mg), give one tablet four times daily as needed for loose bowel/diarrhea. The medication card indicated an expiration date of December 20, 2024, and had 26 capsules remaining. ULP-D confirmed the above listed expired medications. On July 22, 2026, at 11:30 a.m., clinical nurse supervisor (CNS)-B stated she had been reviewing the medication cart for expired medications; however, had missed the above listed medications. The licensee's Storage of Medications dated February 4, 2025, indicated until the medication is set up for immediate or later administration by a nurse, a legend drug must be kept in its original container bearing the original prescription label with legible information stating the prescription number, name of drug, strength and quantity of drug, expiration date of time-dated drug, directions for use, resident's name, prescriber's name, date of issue and the name and address of the licensed pharmacy that issued the medications.	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20339	A. BUILDING: _____ B. WING _____	07/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE COURT ASSISTED LIVING	110 SOUTH HENDERSON STREET HOUSTON, MN 55943

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01890	Continued From page 13 No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01890		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes.	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20339	A. BUILDING: _____ B. WING _____	07/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE COURT ASSISTED LIVING	110 SOUTH HENDERSON STREET HOUSTON, MN 55943

(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
01940	Continued From page 14 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to include on the service plan a written statement of the treatment or therapy services provided for one of four residents (R3) receiving treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3 began receiving assisted living (ALF) services from the licensee on December 8, 2025, with diagnoses including atrial fibrillation, chronic kidney disease (stage 3), type 2 diabetes, anxiety and depression. R3's Service Plan dated April 13, 2026, indicated he received services including medication management/administration, blood sugar monitoring, assistance with compression stockings and showers, and safety checks. R3's Service Plan lacked the service of daily weights. On July 21, 2026, at 7:25 a.m., the surveyor observed unlicensed personnel (ULP)-E set up and administer R3's morning medications and obtained R3's weight. R3's physician visit note dated June 15, 2026, included an order for daily weights.	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20339	A. BUILDING: _____ B. WING _____	07/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE COURT ASSISTED LIVING	110 SOUTH HENDERSON STREET HOUSTON, MN 55943

(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
01940	Continued From page 15 R3's Service Recap Summary dated July 2026, included daily weights completed by the licensee's ULP. R3's Treatment Plan printed July 21, 2026, indicated daily weights to be completed by the ULP and the registered nurse (RN) would review daily weights on a weekly basis. R3's Service Plan lacked the service of daily weights. On July 22, 2026, at 11:25 a.m., clinical nurse supervisor (CNS)-B stated the daily weights were ordered on April 23, 2026, after the most recent Service Plan was reviewed and signed. The daily weights had not been added to the Service Plan. The licensee's Treatment and Therapy Management Plan policy dated May 1, 2025, indicated for each resident at [licensee's name] receiving management of ordered or prescribed treatments or therapy services, the facility will prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01940		

Rochester District Office
Minnesota Department of Health
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

HERITAGE COURT ASSISTED LIVING
110 S HENDERSON STREET
Houston, MN 55943
Houston County
Parcel:

Phone: 507-896-5135
alangheinrich@vvhouston.com

License Info

License: HFID 20339
Amanda Langheinrich
Risk:
License:
Expires on:
CFPM:
CFPM #: ; Exp:

Inspection Info

Report Number: F1045261108
Inspection Type: Full - Single
Date: 7/22/2026 Time: 12:59:38 PM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 1
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

! **New Order: 3-500B Microbial Control: hot and cold holding**
3-501.16A2 *Priority Level: Priority 1 CFP#: 22*
MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.
COMMENT:
The upright ref/freezer residential unit observed with temperatures exceeding 41F. Cheese stored overnight was at 50F. The director noted the warmer temperatures the day prior and adjusted the unit as cold as it would go and still fell short of 41F. She advised this inspector she would be purchasing a new unit. Discussed obtaining a commercial unit for product storage; an effort in ensuring proper temperatures are maintained. All TCS (temperature control for safety) foods were relocated to another unit onsite during inspection.

Provide this inspector with the specs of the new unit prior to purchasing. nicole.hunger@state.mn.us or 507-735-9253
Comply By: Complied On Site *Originally Issued On: 7/22/2026*

Food & Beverage General Comment

Serving kitchen supplied by the "commercial nursing home kitchen and staff". All product is plated in the commercial kitchen and simply handed out to seated residents in the dining area. Bulk milk and beverages poured onsite only. Warewashing occurs in the commercial kitchen.

Reviewed: Employee Illness Policy, handwashing policies and no barehand contact with ready to eat foods, thermometer calibration, cold holding requirements, bio cleanup

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 Rochester District Office inspection report number F1045261108 from 7/22/2026

Amanda Langheinrich
Director

Nicole Hunger,
Public Health Sanitarian 3
507-206-2741
nicole.hunger@state.mn.us

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL20339016	**Date:** 7/21/2026
Facility Name: Heritage Court Assisted Living	
Facility Address: 110 S Henderson St, Houston, MN 55066	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

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

2. Hot work areas shall not contain combustible or shall be provided with appropriate shielding to prevent sparks, slag or heat from igniting exposed combustibles. Hot work operations include cutting, welding, brazing, soldering, grinding, or any other similar activity. [Minn. Stat. 144G.45 subd. 2; MSFC 3504.1.1, MSFC 202]

   Comments: A worktable was set up in the living room of resident room 110 with hot work equipment including equipment for soldering and grinding. An oxygen concentrator was also present in the living room. The resident stated that they engaged in soldering work and build electronics as a hobby. The resident confirmed that they would engage in hot work while oxygen was in use. No safety measures were identified to separate the combustible oxygen from the hot work area. Hot work equipment is not safe to use where oxygen is present.

3. Electrical wiring, devices, appliances and other equipment that is modified or damaged and constitutes an electrical shock or fire hazard shall not be used. [Minn. Stat. 144G.45 subd. 2; MSFC 604.1]

   Comments: An extension cord was in use in resident room 110 that showed evidence of tampering and was taped over in several locations. The extension cord was modified by splicing together several other cords and was not safe. The spliced cord was damaged and posed a shock hazard and fire hazard. The unapproved cord was removed by facility staff during the survey. Extension cords should not be modified and damaged cords should be removed and replaced. Extension cords should not be used in lieu of permanent wiring.

4. Relocatable power taps (power strips) shall be directly connected to a permanently installed receptacle. [Minn. Stat. 144G.45 subd. 2; MSFC 604.4.2]

   Comments: Several power strips were in use in resident room 110 that were connected in sequence. Power strips should not be daisy chained together and should be connected directly to wall outlets.

5. Multiplug adapters, such as cube adapters, unfused plug strips or any other device not complying with NFPA 70 shall be prohibited. [Minn. Stat. 144G.45 subd. 2; MSFC 604.4]

   Comments:

   Several unapproved multiplug adapters were in use in resident room 110. Unapproved multiplug adapters pose a fire risk and should be removed. Only properly listed and approved multiplug adapters should be installed in the facility.

   An unapproved multiplug adapter was in use in resident room 106. Unapproved multiplug adapters pose a fire risk and should be removed. Only properly listed and approved multiplug adapters should be installed in the facility.