STATE LICENSING COMPLIANCE REPORT

Report #: HL363143901C

Date Concluded: September 9, 2026

Name, Address, and County of Facility Investigated:
Second Story LLC
1013 West River Road
Champlin, MN, 55316
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Kris Detsch, RN
Special Investigator

The Minnesota Department of Health conducted a complaint investigation to determine compliance with state laws and rules governing the provision of care under Minnesota Statutes, Chapter 144G. The purpose of this complaint investigation was to review if facility policies and practices comply with applicable laws and rules. No maltreatment under Minnesota Statutes, Chapter 626 was alleged.

To view a copy of the correction orders, if any, please visit: https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html, or call 651-201-4201 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached state form.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36314	A. BUILDING: _____ B. WING _____	C 08/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARDEN HOMES LLC	1013 WEST RIVER ROAD CHAMPLIN, MN 55316

(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 CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: HL363143901C On August 26, 2026, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were three residents receiving services under the provider's Assisted Living license. The following correction orders are issued for HL363143901C, tag identification 485, 1640.	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.	
0 485 SS=F	144G.41 Subdivision 1.a (a) Minimum requirements; required food services	0 485		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36314	A. BUILDING: _____ B. WING _____	C 08/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARDEN HOMES LLC	1013 WEST RIVER ROAD CHAMPLIN, MN 55316

(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
0 485	Continued From page 1 (a) All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide three nutritious meals per day for three of three residents (R1, R2, R3) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 admitted to the licensee for diagnoses	0 485		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36314	A. BUILDING: _____ B. WING _____	C 08/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARDEN HOMES LLC	1013 WEST RIVER ROAD CHAMPLIN, MN 55316

(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
0 485	Continued From page 2 including schizophrenia and depression. R1's addendum to assisted living contact (with included service plan) dated July 23, 2026, indicated the licensee would provide three meals per day, plus additional snacks. R1 had unpredictable behaviors, and required continuous behavioral oversight. R1's customized living rates worksheet dated July 23, 2026, through February 28, 2027, indicated R1 had a history of malnutrition and the licensee would monitor his weight and "track" his progress. R2 R2 admitted to the licensee for diagnoses including paraplegia, depression, and traumatic brain injury (TBI). R2's addendum to assisted living contract (with included service plan) dated July 23, 2026, indicated the licensee would provide three meals per day, plus additional snacks. R2's customized living rates worksheet dated July 23, 2026, through January 31, 2027, indicated the licensee would provide three meals per day, and two snacks. R3 R3 admitted to the licensee for diagnoses including type two diabetes, antisocial personality disorder, seizure disorder, and multiple sclerosis. R3's addendum to assisted living contract (with included service plan) dated July 23, 2026, would provide meals three times per day, plus additional snacks. R3's customized living worksheet dated July 23,	0 485		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36314	A. BUILDING: _____ B. WING _____	C 08/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARDEN HOMES LLC	1013 WEST RIVER ROAD CHAMPLIN, MN 55316

(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
0 485	Continued From page 3 2026, through March 31, 2027, indicated he required the licensee to "set up" his meals, cut and arrange his food three times daily. R3 required staff to give him medications at a minimum of twice daily. R3's master care plan dated July 23, 2026, indicated he required "full" assistance with activities of daily living (ADL) cares. He was non-ambulatory and used an electric wheelchair. R3 required hospice services (end of life). R3 required the licensee to manage his medications, but he independently administered his insulin via an "insulin pump". On August 26, 2026, at 12:29 p.m.,the surveyor entered the licensee. No residents were present. The surveyor observed the licensee's menu posted on the refrigerator. The menu included the following: Breakfast: - French toast sticks (2) - Breakfast sausage - Orange Juice - Butter/jelly - Coffee/tea Lunch: - Salad served with ground beef - 1/2 fruits - Kool aid On August 26, 2026, at 12:51 p.m., the surveyor observed the contents of the licensee's refrigerator and cupboards. The refrigerator contained a variety of condiments and some containers of previously prepared food items. The licensee did not label/identify or date these products. The licensee's cupboard/cabinet contained other food items, including boxed food items such as macaroni products. Although the	0 485		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36314	A. BUILDING: _____ B. WING _____	C 08/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARDEN HOMES LLC	1013 WEST RIVER ROAD CHAMPLIN, MN 55316

(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
0 485	Continued From page 4 licensee did not have food items consistent with their posted menu, food items were available for preparation. On August 26, 2026, at 12:29 p.m., unlicensed personnel (ULP)-A said she was the only staff member working and her shift started at 7:00 a.m. ULP-A said her shift ended at 3:00 p.m. ULP-A said her responsibilities included meal preparation for the residents. ULP-A said all three residents left the facility at approximately 10:00 a.m., but she was unsure where they went or when they would return. ULP-A said she "thought" the residents would return around 2:00 p.m. ULP-A said she did not have the groceries to prepare the food as indicated on the menu, but said manager (M)-C would bring groceries today. ULP-A said she did not give any of the residents breakfast or lunch. ULP-A said generally the residents did not want breakfast anyway. On August 26, 2026, at 2:40 p.m., registered nurse (RN)-B said M-C provided groceries weekly. The licensee's policy titled, Food Safety and Sanitation, dated July 21, 2026, indicated the facility would provide three meals per day, seven days per week. Time period for correction: Seven (7) days	0 485		
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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36314	A. BUILDING: _____ B. WING _____	C 08/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARDEN HOMES LLC	1013 WEST RIVER ROAD CHAMPLIN, MN 55316

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01640	Continued From page 5 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 observation, interview and record reviewed, the licensee failed to implement required behavior management services as indicated on the licensee's customized living worksheet (commonly known as the 6790) for three of three residents (R1, R2, R3) with record reviewed. 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:	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36314	A. BUILDING: _____ B. WING _____	C 08/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARDEN HOMES LLC	1013 WEST RIVER ROAD CHAMPLIN, MN 55316

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01640	Continued From page 6 R1 R1 admitted to the licensee for diagnoses including schizophrenia and depression. R1's customized living worksheet dated August 26, 2026, written by the licensee and submitted to the case manager (CM) for payment of services July 23, 2026, through February 28, 2027. The form included the following services and time required to complete the service: -Homemangement, including housekeeping, 0.75 hours per day -One staff to one resident (1:1) socialization, 0.5 hours per day -Assistance with bathing, 0.16 hours per day -Medication reminders, 0.5 hours per day -Medication Set-up, 0.5 hours per day -Other delegated tasks to monitor weight and vital signs, 0.5 hours per day -Manage wandering, 3 hours per week (0.43 hours per day) -Manage orientation issues, 7 hours per week (1 hour per day) -Manage anxiety, 14 hours per week (2 hours per day) -Manage repetitive behavior, 10 hours per week (1.43 hours per day) -Manage verbal aggression, 7 hours per week (1 hour per day) -Manage physical aggression, 5 hours per week (0.71 hours per day) -Manage property destruction, 6 hours per week (0.86 hours per day) -Manage alcohol abuse, 7 hours per week (1 hour per day) -Manage delusions and hallucinations, 7 hours per week (1 hour per day) -One staff to two to five residents (1:2-5) socialization, 1 hour per day	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36314	A. BUILDING: _____ B. WING _____	C 08/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARDEN HOMES LLC	1013 WEST RIVER ROAD CHAMPLIN, MN 55316

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01640	Continued From page 7 -Manage self-injurious behavior, 7 hours per week (1 hour per day) R1 required a total of 13.34 hours of individualized services per day. R1's addendum to assisted living contact (with included service plan) dated July 23, 2026, indicated the licensee would provide the following services: -Bathing reminders daily -Homemanagement -Medication administration twice daily -Medication set-up weekly -Socialization twice daily -Vital sign monitoring weekly -Manage behavior, agitation -Manage behavior, anxiety -Manage behavior, other mental health need -Manage behavior, physical aggression -Manage behavior, property destruction -Manage behavior, self-injurious -Manage behavior, verbal aggression -Manage symptom, wandering R1's service plan failed to provide vital sign and weight monitoring daily as required by the customized living worksheet. Progress notes dated August 16, 2026, indicated R1 fell while in the community and went to the hospital. The note indicated R1 was visiting friends at an alternative location on August 15, 2026, when the fall occurred. R1 returned to the licensee some time on August 16, 2026. The note indicated the licensee did not receive a discharge summary or other medical records. The notes failed to identify when R1 left the facility on August 15, 2026, or what/any actions they took to determine his "whereabouts" when he did not return until August 16, 2026.	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36314	A. BUILDING: _____ B. WING _____	C 08/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARDEN HOMES LLC	1013 WEST RIVER ROAD CHAMPLIN, MN 55316

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01640	Continued From page 8 Service recap summary dated August 1, 2026, through August 31, 2026, indicated R1 was "out of the building" on August 15, 2026, in the evening. Documentation erroneously indicated staff completed evening medication administration and monitoring of property destruction and self-injurious behavior. On August 16, 2026, all staff documented they completed all morning services. The service summary failed to indicated the licensee implemented hourly checks for staff to monitor R1's hallucinations or delusions. The service summary indicated staff complete behavior management twice per day on morning and evening shift. R2 R2 admitted to the licensee for diagnoses including paraplegia, depression, and traumatic brain injury (TBI). R2's customized living worksheet undated, written by the licensee and submitted to the CM for payment of services July 23, 2026, through January 31, 2027, included the following services and time requirements: -Homemaking, including housekeeping, 1 hour per day -Shopping, 1.5 hours per week -1:1 Socialization, 1 hour per day. -1:2-5 Socialization, 0.5 hours per day -Assistance with dressing, 0.5 hours per day -Assistance with grooming, 0.5 hours per day -Assistance with bathing, 0.75 hours per day (7 times per week) -Incontinence care, 2.04 hours per day -Assistance with positioning, 0.96 hours per day -Assistance with transferring, 1.5 hours per day -Assistance with medication administration, 0.5 hours per day	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36314	A. BUILDING: _____ B. WING _____	C 08/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARDEN HOMES LLC	1013 WEST RIVER ROAD CHAMPLIN, MN 55316

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01640	Continued From page 9 -Medication reminders, 0.08 hours per day -Blood pressure monitoring daily, 0.25 hours per day -Medication Set-Up by nurse, 2 hours per week -Managing impulse control, 3 hours per day. -Managing depression, 2 hours per day -Managing forgetfulness, 2 hours per day R2 required a total of 16.08 hours of individualized services per day. R2's addendum to assisted living contract (with included service plan) dated July 23, 2026, indicated the licensee would provide the following services: -Bathing, three days per week -Dressing twice per day -Grooming twice per day -Homemanagement -Medication administration twice per day -vital sign monitoring, including blood pressure once per week -socialization twice per day -Toileting assistance five times daily -Transfer assistance three times daily -Manage behavior, other mental health need -Manage symptom, depression -Manage symptom, other mental health need R2's service plan failed to provide bathing assistance daily and blood pressure monitoring daily as required by the customized living worksheet. Progress notes dated July 23, 2026, at 6:30 p.m., indicated an administrator who worked at a different care facility went to the licensee and informed the administrator they "trespassed" R2 from the administrator's property because he purchased and provided alcohol for their residents which caused disturbances at their	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36314	A. BUILDING: _____ B. WING _____	C 08/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARDEN HOMES LLC	1013 WEST RIVER ROAD CHAMPLIN, MN 55316

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01640	Continued From page 10 facility. It was unclear from the progress note, when the other facility completed the trespass order, however the note indicated the administrator told the licensee R2 continued to go to the facility after the trespass occurred. The same progress note indicated the licensee was informed (by whom was not identified), approximately 30 minutes after this interaction, law enforcement arrested R2 and took him into custody. This incident did not occur on the licensee's premises. Progress notes lacked any further indication when the R2 left the facility, or when he returned. Progress notes failed to identify what prompted the interaction with law enforcement. The licensee completed no other progress notes until August 6, 2026. This progress noted indicated registered nurse (RN)-B completed a routine assessment due to the licensee's change in ownership. Service recap summary dated August 1, 2026, through August 31, 2026, indicated staff to completed behavior management each shift. R3 R3 admitted to the licensee for diagnoses including type two diabetes, antisocial personality disorder, seizure disorder, and multiple sclerosis. R3's customized living worksheet dated August 26, 2026, written by the licensee and submitted to the CM for payment of services July 23, 2026, through March 31, 2027, included the following services and time required for the service: -Home management, including housekeeping, 1.5 hours per day -Assistance with dressing, 0.66 hours per day -Assistance with grooming, 0.5 hours per day -Assistance with bathing, 2.25 hours per week (0.32 hours per day)	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36314	A. BUILDING: _____ B. WING _____	C 08/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARDEN HOMES LLC	1013 WEST RIVER ROAD CHAMPLIN, MN 55316

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01640	Continued From page 11 -Incontinence care, 4 hours per day -Assistance with eating, 0.5 hours per day -Assistance with transferring, 1 hour per day -Assistance with medication administration, 1 hour per day -Medication Set-up by nurse, 0.5 hours per day (done weekly in the care note) -Daily blood pressure monitoring, 0.5 hours per day -1:1 socialization (twice per day for 1 hour), 2 hours per day -1: 2-5 socialization, 1 hour per day -Manage anxiety, 7 hours per week (1 hour per day) -Manage self-injurious behavior, 14 hours per week (2 hours per day) -Manage other mental health needs, 14 hours per week (2 hours per day). The licensee indicated R3 required observation of his behavioral responses such as hyperactivity, disorientation, confusion, sleeplessness, and irritability. R3 required 1:1 staffing levels to create a calm environment and remove stressors. R3 required close supervision of his activities. -Manage substance abuse disorders, 14 hours per week (2 hours per day) R3 required a total of approximately 18.5 hours of individualized services per day, excluding the medication set-up. R3's addendum to assisted living contract (with included service plan) dated July 23, 2026, indicated licensee would provide the following services: -Bathing assistance three days per week -Assistance with dressing twice daily -Assistance with grooming twice daily -Toileting assistance five times daily -Transfer assistance two times daily -Homemanagement	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36314	A. BUILDING: _____ B. WING _____	C 08/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARDEN HOMES LLC	1013 WEST RIVER ROAD CHAMPLIN, MN 55316

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01640	Continued From page 12 -Medication Administration four times daily -Medication set-up once per week -Daily vital signs, including blood pressure -Manage behavior, anxiety -Manage behavior, self-injury -Manage behavior, other mental health needs -Socialization twice daily R3's service plan failed to include daily eating assistance as required by the customized living worksheet. Service recap summary dated August 1, 2026, through August 31, 2026, indicated staff to completed behavior management each shift. R3 refused daily blood pressure checks consistently. Progress notes dated July 23, 2026, through August 20, 2026, indicated R3 also received services from a hospice agency. The licensee's staffing schedule dated August 24, 2026, through August 30, 2026, indicated one unlicensed personnel (ULP) worked each shift. The facility failed to provide 1:1 staffing ratio for R1, R2 and R3's required daily 1:1 socialization time. Additionally, the residents required a total of 47.92 hours of individualized services compared to 24 hours per day of staff available to provide services. On August 26, 2026, at 12:29 p.m., ULP-A said she was the only staff member working at the licensee and her shift started at 7:00 a.m. ULP-A said her shift ended at 3:00 p.m. ULP-A said the licensee staffed one ULP per shift, and showed the surveyor the staffing schedule on her phone which supported her statement. ULP-A said her responsibilities included medication	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36314	A. BUILDING: _____ B. WING _____	C 08/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARDEN HOMES LLC	1013 WEST RIVER ROAD CHAMPLIN, MN 55316

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01640	Continued From page 13 administration, activities of daily living (ADL) cares, and meal preparation for the residents. ULP-A said all three residents left the facility at approximately 10:00 a.m., but she was unsure where they went or when they would return. ULP-A said she "thought" the residents would return around 2:00 p.m. ULP-A said the licensee did not have a system in plan to track the "comings/goings" of the residents. ULP-A was unsure what actions would occur if a resident did not return (missing resident), but said she would call RN-B. ULP-A was unclear when the licensee would consider a resident "missing." ULP-A said the residents did not have behaviors (negative), but said R3 did consume alcohol occasionally. ULP-A said if an incident occurred, she would call emergency services (911). The licensee's policy titled, Service Plan, dated July 21, 2026, indicated the licensee would ensure every resident received services/care that matched an assessed and documented needs. Time period for correction: Seven (7) Days	01640		