Electronically Delivered

November 4, 2026

Licensee
Sotam Home Care LLC
9271 Lake Road
Woodbury, MN 55125

RE: Project Number(s) SL35673016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 13, 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 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $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

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,

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

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35673	A. BUILDING: _____ B. WING _____	10/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOTAM HOME CARE LLC LLC	9271 LAKE ROAD WOODBURY, MN 55125

(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: SL35673016-0 On October 12, 2026 through October 13, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were four (4)residents; 4 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.	
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an assisted living director who is licensed or permitted by the Board of Executives for Long Term Services and Supports and affiliated as the director of record with the board.	0 110		

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0 110	Continued From page 1 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record for the licensee with the Minnesota Board of Executives for Long-Term Services and Support (BELTSS). This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's staff roster, dated September 2026, identified LALD-D's hire date of June 23, 2022. During the entrance conference on October 12, 2026, at 9:45 a.m., administrator (A)-F stated LALD-D had been the licensee's LALD on and off since 2022 but consistently since 2025. A-F stated she had a residency LALD permit which expired as she didn't take the test, so LALD-D became the acting LALD. On October 12, 2026, at 1:52 p.m., the BELTSS website indicated LALD-D currently held an assisted living director license, effective June 23, 2021; LALD-D was not identified as the Director	0 110		

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0 110	Continued From page 2 of Record for the licensee. Additionally, the website indicated LALD-D's affiliation with licensee ended September 4, 2024, and there was no LALD listed for the licensee. On October 13, 2026, at 11:37 a.m., LALD-D stated he had not registered with BELTSS as Director of Record for the licensee. LALD-D further stated that he was the LALD at two other facilities, one of which was owned by the same owner which he was also not listed as the LALD for. LALD-D stated he had rejoined the company about two months ago. LALD-D stated "they" were working on a contract. The surveyors were unable to obtain further information as LALD-D did not come on-site during survey and connection for LALD-D's phone service was poor (on October 13, 2026, between 11:37 a.m. and 11:52 a.m. - a total of five calls made that would disconnect and were difficult to hear which were the only times that surveyors were able to connect with LALD-D). No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
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	0 480		

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0 480	Continued From page 3 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 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	0 480		

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0 480	Continued From page 4 (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 October 12, 2026, received October 19, 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	0 510		

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0 510	Continued From page 5 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 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 all 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 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 facility was a split-level single-family home with one bathroom on the main level and a second on the lower level. On October 12, 2026, at 10:00 a.m., during the	0 510		

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0 510	Continued From page 6 facility tour, the surveyor observed the main level bathroom toilet; the lid was in the up-position, and the seat was saturated in urine. On October 12, 2026, at 12:25 p.m., the surveyor observed the main level bathroom toilet; the lid was in the up-position, and the seat was saturated in urine, some of the urine spots were dried. On October 12, 2026, at 1:14 p.m., the surveyor observed the main level bathroom toilet; the lid was in the up-position, and the seat was saturated in urine, some of the urine spots were dried. On October 13, 2026, at 8:56 a.m., the surveyor observed the main level bathroom toilet; the lid was in the up-position, and the seat was saturated in urine, there was more dried urine than the day before with new wet urine covering the seat. On October 13, 2026, at 12:28 p.m., R4 stated the bathroom was regularly dirty, and they were sometimes unable to use the bathroom on the main level. R4 stated they usually ended up cleaning the main level bathroom themselves. On October 13, 2026, at 12:33 p.m., the surveyor showed administrator (A)-F the main level bathroom toilet seat. A-F stated they were disappointed the toilet seat had wet and dry urine all over it; they took a picture of the toilet seat. The surveyor explained the toilet had been in its current state since the day prior during the facility tour. A-F stated the staff typically cleaned the bathroom on the weekends but should also be cleaning it whenever it was dirty. Clinical nurse supervisor (CNS)-A stated the bathroom cleaning	0 510		

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0 510	Continued From page 7 was a problem which presented an infection control issue. CNS-A stated the bathroom should be cleaned regularly and as needed. The Center for Disease Control (CDC) website for Environmental Cleaning Procedures in healthcare facilities, dated March 19, 2026, 4.3 Patient Area Toilets subsection, indicated, "Toilets in patient care areas can be private (within a private patient room) or shared (among patients and visitors). They have high patient exposure (i.e., high-touch surfaces) and are frequently contaminated. Therefore, they pose a higher risk of pathogen transmission than in general patient areas." It further indicated, on Table 10, the recommended frequency, method and process for patient area toilet cleanings occur as follows: patient public and shared toilets (e.g., patients, visitors, family member) cleaned at least twice daily cleaning and disinfecting high-touch and frequently contaminated surfaces in toilet areas (e.g., handwashing sinks, faucets, handles, toilet seat, door handles) and floors. The licensee's Infection Control policy dated August 1, 2021, indicated: "Cleaning/Decontaminating Spills of Blood/Body Fluids 1. Chemical germicides such as those used as hospital disinfectants can be used to decontaminate spills for blood and other body fluids. They should be diluted according to label directions. 2. Staff should remove all visible material and decontaminate the area. 3. Gloves should be worn during the cleaning and decontamination. 4. Soiled linens should be handled as little as possible and with minimum agitation to prevent gross microbial contamination of the air and of	0 510		

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0 510	Continued From page 8 persons handling the linen. 5. All soiled linen should be bagged at the location where it was used; it should not be sorted or rinsed in resident-care areas. 6. If hot water is used, linen should be washed with detergent in water at least 71 C (160F). 7. If low temperature laundry cycles are used, chemicals suitable for low-temperature washing at concentrations as per labeled directions should be used." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the	0 660		

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0 660	Continued From page 9 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 completion of a two-step tuberculin skin test (TST) or TB blood test for one of two employees (unlicensed personnel (ULP)-B). 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: The licensee's Facility TB Risk Assessment, dated May 1, 2026, indicated the facility was at a low risk for TB transmission. ULP-B was hired May 26, 2026, and provided direct care for residents of the facility. ULP-B's record included documentation of a completed TB history and symptom screening form and a single-step TST, dated June 19, 2026. ULP-B's record lacked documentation of a second-step TST or TB blood test. On October 13, 2026, at 10:36 a.m., during a joint interview, clinical nurse supervisor (CNS)-A, administrator (A)-F, and resident staff interaction coordinator (RSIC)-E stated ULP-B only completed one TST. CNS-A stated they oversaw the TB prevention program. A-F and RSIC-E stated they were not aware of the definition and	0 660		

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0 660	Continued From page 10 requirement of a two-step TST and assisted with ensuring staff completed the required testing prior to starting. A-F stated the majority of staff completed the TB blood test. The licensee's policy 4.14 Tuberculosis Screening/Prevention reviewed July 15, 2026, indicated "Baseline TB Testing: Baseline TB screening at the time of hire is required for all HCWs in Minnesota. Baseline TB screening consists of three components: (1) assessing for current symptoms of active TB disease, and (2) assessing TB history and 3) TB testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single TB blood test. baseline TB screening would be required for all health care workers and this screening would include testing by either a two-step TST or a single blood test." The CDC's Baseline Tuberculosis Screening and Testing for Health Care Personnel dated December 19, 2023, recommended all health care professionals complete a TB screening including a baseline individual TB risk assessment, symptom evaluation, a TB test (a blood test or 2-step TST) and follow up as needed. Furthermore, if the Mantoux tuberculin skin test (TST) is used for baseline testing of healthcare workers, use two-step testing. The MDH Regulations for TB Control in Minnesota Health Care Settings, updated April 15, 2026, indicated baseline TB screening consists of three components: 1. Assessing for current symptoms of active TB disease, 2. Assessing TB history, and 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering	0 660		

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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
0 660	Continued From page 11 either a two-step TST or single IGRA. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
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	0 730		

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	35673	A. BUILDING: _____ B. WING _____	10/13/2026

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0 730	Continued From page 12 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 and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure resident records included documentation of services provided for three of three residents (R2, R3, R5). 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: R2 R2 was admitted to the licensee on July 1, 2020. R2's Service Plan dated April 2, 2026, and signed	0 730		

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0 730	Continued From page 13 April 3, 2026, indicated R2 received services for activity assistance, assistance with self-administration of medication, bathing assistance-shower or bath, behavior management (changes in presentation/identity, orientation issues, repetitive behaviors, agitation, wandering, hallucinations/delusions and anxiety), declutter room, deep room clean, delegated clinical monitoring, dressing, housekeeping, laundry, linen change, meal assistance, medication management, medication set up, vital signs (blood pressure, oxygen saturation, pulse, respiration, temperature and weight), safety checks, shopping assistance, and symptom screen. On October 12, 2026, at 2:13 p.m., the surveyor observed unlicensed personnel (ULP)-C administer medications for R2. R2's Task Administration Record (service plan documentation record) for September and October 2026, indicated the licensee lacked documentation for the following services and dates: -safety check; October 7 at 12:00 a.m.; -safety check; October 7 at 2:00 a.m.; -safety check; September 28 and October 7 at 4:00 a.m.; -safety check; September 28 and October 4, 7 at 6:00 a.m.; -behavior management manage orientation issues; AM; September 10, 20; -behavior management manage repetitive behavior; AM; September 10, 20; -behavior management manage agitation; AM; September 10, 20; -behavior management manage wandering; AM; September 10, 20; -behavior management manage anxiety; AM;	0 730		

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0 730	Continued From page 14 September 10, 20; -behavior management other cognitive/mental health need; AM; September 10, 20; -behavior management hallucinations/delusions; AM; September 10, 20; -medication set up; September 5, 12, 19, 26 and October 4 and 10; -symptom screen; September 10, 20 and October 12; -safety check; September 20 at 11:00 a.m.; -safety check; September 20 at 12:00 p.m.; -activity assistance; September 20; -declutter room; September 20; -housekeeping; September 20; -meal assistance; September 20; -activity assistance; September 20; -safety check; September 20 at 1:00 p.m.; -safety check; September 20 at 2:00 p.m.; -behavior management manage orientation issues; overnight; September 20, 27 and October 6; -behavior management manage repetitive behavior; overnight; September 20, 27 and October 6; -behavior management manage agitation; overnight; September 20, 27 and October 6; -behavior management manage wandering; overnight; September 20, 27 and October 6; -behavior management manage anxiety; overnight; September 27 and October 6; -behavior management other cognitive/mental health needs; overnight; September 20, 27 and October 6; -behavior management hallucinations/delusions; overnight; September 27 and October 6; and -medication administration; 2:00 p.m.; September 20 and October 11. R3 R3 was admitted to the licensee on June 27,	0 730		

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0 730	Continued From page 15 2022. R3's Service Plan dated and signed September 9, 2023, indicated R3 received services for activity assistance, bathing reminder, behavior management (verbal aggression, orientation issues, repetitive behaviors, agitation, wandering, anxiety, other cognitive/mental health need, physical aggression, elopement, hallucinations/delusions, sexually inappropriate and property destruction), deep room clean, dressing, grooming, housekeeping, laundry, medication administration, medication set up, vital signs (blood pressure, oxygen saturation, pulse, respiration, temperature, weight), remove garbage, safety checks, shopping assisting, symptom screen, and wasting of food. R3's Task Administration Record for September and October 2026 indicated the licensee lacked documentation for the following services and dates; -safety check; September 28 at 4:00 a.m.; -safety check; September 28 at 6:00 a.m.; -activity assistance; AM; September 20; -behavior management manage verbal aggression; AM; September 10, 20; -behavior management manage orientation issues; AM; September 10, 20; -behavior management manage repetitive behavior; AM; September 10, 20; -behavior management manage agitation; AM; September 10, 20; -behavior management manage wandering; AM; September 10, 20; -behavior management manage anxiety; AM; September 10, 20; -behavior management other cognitive/mental health need; AM; September 10, 20; -behavior management manage physical	0 730		

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0 730	Continued From page 16 aggression; AM; September 10, 20; -behavior management elopement; AM; September 10, 20; -behavior management hallucinations/delusions; AM; September 10, 20; -behavior management sexually inappropriate; AM; September 10, 20; -manage property destruction; AM; September 20; -symptom screen; AM; September 10, 20 and October 12; -wasting of food; AM; September 20 -housekeeping; AM; September 20; -safety check; September 20 at 11:00 a.m.; -safety check; September 20 at 12:00 p.m.; -safety check; September 20 at 1:00 p.m.; -safety check; September 20 at 2:00 p.m.; -remove garbage; September 20 at 2:00 p.m.; -behavior management manage verbal aggression; overnight; September 27 and October 6; -behavior management manage orientation issues; overnight; September 27 and October 6; -behavior management manage repetitive behavior; overnight; September 27 and October 6; -behavior management manage agitation; overnight; September 27 and October 6; -behavior management manage wandering; overnight; September 27 and October 6; -behavior management manage anxiety; overnight; September 27 and October 6; -behavior management other cognitive/mental health needs; overnight; September 27 and October 6; -behavior management manage physical aggression; overnight; September 27 and October 6; -behavior management elopement; overnight; September 27 and October 6;	0 730		

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0 730	Continued From page 17 -behavior management hallucinations/delusions; overnight; September 27 and October 6; -behavior management sexually inappropriate; overnight; September 27 and October 6; -manage property destruction; overnight; September 27 and October 6; and -wasting of food; overnight; September 27 and October 6. R5 R5 was admitted to the licensee on June 29, 2026. R5's Service Plan dated and signed June 29, 2026, indicated R5 received services for behavior management (verbal aggression, repetitive behavior and anxiety). R5's Task Administration Record for September and October 2026 indicated the licensee lacked documentation for the following services and dates; -behavior management manage verbal aggression; AM; September 10, 20; -behavior management manage repetitive behavior; AM; September 10, 20; -behavior management manage anxiety; AM; September 10, 20; -behavior management other cognitive/mental health need; AM; September 10, 20; -behavior management physical aggression; AM; September 10, 20; -behavior management manage verbal aggression; overnight; September 20 and October 6; -behavior management manage repetitive behavior; overnight; September 20 and October 6; -behavior management manage anxiety; overnight; September 20, 27 and October 6;	0 730		

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0 730	Continued From page 18 -behavior management other cognitive/mental health need; overnight; September 20 and October 6; and -behavior management physical aggression; overnight; September 20, 27 and October 6. On October 13, 2026, at 10:27 a.m., during a joint interview with clinical nurse supervisor (CNS)-A, administrator (A)-F, and resident staff interaction coordinator (RSIC)-E, they reviewed R2, R3 and R5's Task Administration Record (TAR) for September and October 2026 and stated the services a resident received should be documented. CNS-A stated the TARs were missing documentation, and their expectation was the records be complete. RSIC-E stated audits were being completed every 90 days, but they recently increased how often they were being completed to ensure there was no missing documentation of services provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
0 780 SS=C	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms;	0 780		

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0 780	Continued From page 19 (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated October 13 2026, for the specific violations	0 780		

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0 780	Continued From page 20 related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 800 SS=B	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include:	0 800		

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0 800	Continued From page 21 Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated October 13 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 920 SS=C	144G.50 Subd. 2 (c) Contract information (c) The contract must include: (1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; (2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; (3) a delineation of the cost and nature of any other services to be provided for an additional fee; (4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; (5) a delineation of the grounds under which the resident may be transferred or have housing or services terminated or be subject to an emergency relocation; (6) billing and payment procedures and requirements; and (7) disclosure of the facility's ability to provide specialized diets. This MN Requirement is not met as evidenced	0 920		

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0 920	Continued From page 22 by: Based on interview and record review, the licensee failed to ensure the assisted living contract included a delineation of costs for the contracted services. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's blank Resident Contract for Assisted Living template, undated, lacked the following required information: -a delineation of the cost and nature of any other services to be provided for an additional fee; and -a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract. R2 R2 was admitted to the licensee on July 1, 2020. R2's Service Plan dated April 2, 2026, and signed April 3, 2026, indicated R2 received services for activity assistance, assistance with self-administration of medication, bathing assistance-shower or bath, behavior management (changes in presentation/identity, orientation issues, repetitive behaviors, agitation, wandering, hallucinations/delusions and anxiety), declutter room, deep room clean, delegated	0 920		

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0 920	Continued From page 23 clinical monitoring, dressing, housekeeping, laundry, linen change, meal assistance, medication management, medication set up, vital signs (blood pressure, oxygen saturation, pulse, respiration, temperature and weight), safety checks, shopping assistance, and symptom screen. R2's Resident Contract for Assisted Living signed October 1, 2024, did not identify a delineation and description of any additional fees the resident may be required to pay if the resident's condition changed during the term of the contract. R3 R3 was admitted to the licensee on June 27, 2022. R3's Service Plan dated and signed September 9, 2023, indicated R3 received services for activity assistance, bathing reminder, behavior management (verbal aggression, orientation issues, repetitive behaviors, agitation, wandering, anxiety, other cognitive/mental health need, physical aggression, elopement, hallucinations/delusions, sexually inappropriate and property destruction), deep room clean, dressing, grooming, housekeeping, laundry, medication administration, medication set up, vital signs (blood pressure, oxygen saturation, pulse, respiration, temperature, weight), remove garbage, safety checks, shopping assisting, symptom screen, and wasting of food. R3's Resident Contract for Assisted Living signed October 1, 2024, did not identify a delineation and description of any additional fees the resident may be required to pay if the resident's condition changed during the term of the contract.	0 920		

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0 920	Continued From page 24 R5 R5 was admitted to the licensee on June 29, 2026. R5's Service Plan dated and signed June 29, 2026, indicated R5 received services for behavior management (verbal aggression, repetitive behavior and anxiety). R5's Resident Contract for Assisted Living signed June 29, 2026, did not identify a delineation and description of any additional fees the resident may be required to pay if the resident's condition changed during the term of the contract. On October 13, 2026, at 11:20 a.m., during a joint interview with administrator (A)-F and resident staff interaction coordinator (RSIC)-E, they reviewed contracts used for R2, R3, and R5. A-F stated no contracts that have been used included a delineation of cost including R2, R3, and R5's contracts. A-F stated she was unaware that the assisted living contracts for residents who received waivered services needed to have the delineation of costs. A-F and RSIC-E stated they do not have any delineation of costs and had not provided a delineation of costs in any form to any residents on waivers and the facility had never accepted a private pay resident. A-F and RSIC-E were unaware the delineation of costs needed to be provided to residents on waivers. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 920		
01610 SS=D	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring	01610		

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01610	Continued From page 25 (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 initial nursing assessment prior to signing the assisted living contract and providing services for one of one resident (R5). 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:	01610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35673	A. BUILDING: _____ B. WING _____	10/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOTAM HOME CARE LLC LLC	9271 LAKE ROAD WOODBURY, MN 55125

(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 26 R5 was admitted on June 29, 2026, and had diagnoses including dissociative identity disorder (multiple personality disorder), schizoaffective disorder (mental health disorder which is characterized by symptoms of schizophrenia and bipolar mood disorder), borderline personality disorder (mental health condition marked by lasting patterns of unstable emotions, impulsive behavior, and troubled relationships), posttraumatic stress disorder (PTSD), and obsessive-compulsive disorder mixed obsessional thoughts and acts (characterized by the simultaneous presence of both intrusive, distressing obsessions and repetitive compulsive behaviors or mental acts). R5's Service Plan dated and signed June 29, 2026, indicated R5 received services for behavior management (verbal aggression, repetitive behavior and anxiety). R5's record lacked an initial nursing admission assessment completed by a registered nurse of the physical and cognitive needs of the prospective resident prior to the date on which a prospective resident executed a contract with a facility or the date on which a prospective resident moved in, whichever was earlier. R5's record had an admission assessment completed by a registered nurse on June 30, 2026 (one day after admission). On October 13, 2026, at 10:22 a.m., clinical nurse supervisor (CNS)-A stated R5 moved in the facility on June 29, 2026, and the admission assessment was completed on June 30, 2026. CNS-A stated R5 moved in later in the day and was tired. CNS-A stated she thought she had five days to complete an admission assessment.	01610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35673	A. BUILDING: _____ B. WING _____	10/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOTAM HOME CARE LLC LLC	9271 LAKE ROAD WOODBURY, MN 55125

(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 27 On October 13, 2026, at 11:20 a.m., administrator (A)-F stated R5 moved in the facility with a signed contract on June 29, 2026. A-F stated they thought the nurse had five days to complete the initial nursing assessment. The licensee's 2.3 Assessment and Reassessment policy reviewed July 15, 2026, indicated "the initial RN assessment shall be completed prior to the date on which the prospective resident executes a contract or on the date on which the prospective resident moves in, whichever is earlier." No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01610		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35673	A. BUILDING: _____ B. WING _____	10/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOTAM HOME CARE LLC LLC	9271 LAKE ROAD WOODBURY, MN 55125

(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
01620	Continued From page 28 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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a comprehensive reassessment at least every 90 days for one of two residents (R2).	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35673	A. BUILDING: _____ B. WING _____	10/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOTAM HOME CARE LLC LLC	9271 LAKE ROAD WOODBURY, MN 55125

(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
01620	Continued From page 29 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 July 1, 2020. R2's Service Plan dated April 2, 2026, and signed April 3, 2026, indicated R2 received services for activity assistance, assistance with self-administration of medication, bathing assistance-shower or bath, behavior management (changes in presentation/identity, orientation issues, repetitive behaviors, agitation, wandering, hallucinations/delusions and anxiety), declutter room, deep room clean, delegated clinical monitoring, dressing, housekeeping, laundry, linen change, meal assistance, medication management, medication set up, vital signs (blood pressure, oxygen saturation, pulse, respiration, temperature and weight), safety checks, shopping assistance, and symptom screen. R2's two most recent comprehensive assessments were completed as follows: -March 25, 2026, comprehensive assessment; and -June 26, 2026, comprehensive assessment (93 days since last comprehensive assessment). No additional comprehensive assessments were	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35673	A. BUILDING: _____ B. WING _____	10/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOTAM HOME CARE LLC LLC	9271 LAKE ROAD WOODBURY, MN 55125

(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
01620	Continued From page 30 completed after June 26, 2026. R2's progress notes dated September 1, 2026, to October 12, 2026, lacked any notes regarding refusal or attempts to complete the comprehensive assessment. On October 12, 2026, at 2:13 p.m., the surveyor observed unlicensed personnel (ULP)-C administer medications for R2. On October 13, 2026, at 10:24 a.m., clinical nurse supervisor (CNS)-A reviewed R2's most recent comprehensive assessment. CNS-A stated it must have been an oversight as R2 was overdue for an assessment and the previous assessment was late. CNS-A stated the electronic medical record system the licensee utilized could set up reminders for when assessments are due, but the reminders were not currently set up. CNS-A stated the requirement was to complete a comprehensive assessment at least every 90 days in addition to an admission assessment, 14-day assessment, and change of condition assessment which they were responsible for. The licensee's 2.3 Assessment and Reassessment policy reviewed July 15, 2026, indicated "ongoing resident reassessments must be conducted by an RN and cannot exceed 90 days from the last date of assessment." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		

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

SOTAM HOMECARE LLC
9271 Lake Road
Woodbury, MN 55125
Washington County
Parcel:

Phone:
sotam.homecare@gmail.com

License Info

License: HFID 35673

Risk:
License:
Expires on:
CFPM: Destina Brownwest
CFPM #: 66946; Exp: 4/30/2029

Inspection Info

Report Number: F1031261335
Inspection Type: Follow-up - Single
Date: 10/19/2026 Time: 11am
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 2
Total Priority 3 Orders: 1
Delivery:

Previous Order: 6-300 Physical Facility Numbers and Capacities
6-301.11 *Priority Level: Priority 2 CFP#: 10*
MN Rule 4626.1440 Provide an adequate supply of hand soap at each handwashing sink or group of 2 adjacent handwashing sinks.
COMMENT:
BATHROOM HANDWASH STATION MISSING SOAP.
PIC STOCKED SOAP IMMEDIATELY.

Comply By: Complied On Site Originally Issued On: 10/12/2026

Previous Order: 6-300 Physical Facility Numbers and Capacities
6-301.12 *Priority Level: Priority 2 CFP#: 10*
MN Rule 4626.1445 Provide and maintain a supply of individual disposable towels, a continuous towel system, a heated-air hand drying device, or an approved ambient air temperature hand drying device at each handwashing sink or group of adjacent handwashing sinks.
COMMENT:
KITCHEN AND BATHROOM HANDWASH STATIONS MISSING PAPER TOWELS.
PIC STOCKED IMMEDIATELY.

Comply By: Complied On Site Originally Issued On: 10/12/2026

Previous 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:
TWO CUPBOARDS HAVE INTERIOR SPICES/DEBRIS/SPILLS.
CLEAN CUPBOARD INTERIORS.
WASH CUPBOARD LINERS AS NEEDED TO PREVENT BUILDUP.

Comply By: 11/2/2026 Originally Issued On: 10/12/2026

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 F1031261335 from 10/19/2026

Establishment Representative

Chris Foster, REHS/RS
Public Health Sanitarian 3
651-201-4728
chris.j.foster@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

SOTAM HOMECARE LLC
Woodbury
County/Group: Washington County

Inspection Info

Report Number: F1031261335
Inspection Type: Follow-up
Date: 10/19/2026
Time: 11am

Equipment Temperature: Product/Item/Unit: Thermometer**; Temperature Process:** Ambient Air
Location: Refrigerator at 31 Degrees F.
Comment:
Violation Issued?: No

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL35673016-0	**Date:** 10/13/2026
Facility Name: Sotam Homecare LLC	
Facility Address: 9271 Lake Rd, Woodbury, MN 55125	

☒ **TAG IDENTIFICATION: 0780**

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

1. Smoke Alarm power supply complies with MN State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated. [Minn. Stat. 144G.45 subd.2]

   Comments: On the main and lower levels in the hallways the hardwired smoke alarms were removed, and battery powered smoke alarms were installed. Hardwired smoke alarms shall be reinstalled on both the main and lower levels in the hallways.

2. Smoke alarms shall be interconnected so that actuation of one alarm causes all alarms in the individual dwelling or sleeping unit to operate where more than one smoke alarm is required within an individual dwelling or sleeping unit. [Minn. Stat. 144G.45 subd.2]

   Comments: The hardwired smoke alarms that were missing on the main and lower level hallways shall be interconnected with all other smoke alarms in the facility.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 1; Pattern **TIME PERIOD OF CORRECTION:** Twenty One (21) days

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

   Comments: In resident room 3 the window screens were missing, which could allow insects to enter the room.

The lower level hallway ceiling light did not function and had a note taped to it saying faulty light.