Electronically Delivered

October 20, 2026

Licensee
Souriyathy Housing With Services
10932 Gettysburg Avenue North
Champlin, MN 55316

RE: Project Number(s) SL36560016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 10, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $1,000.00
0810 - 144g.45 Subd. 2 (b-F) - 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 $1,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

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

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

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

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,



Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36560	A. BUILDING: _____ B. WING _____	09/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIYATHY HOUSING WITH SERVIC	10932 GETTYSBURG AVENUE NORTH 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 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: SL36560016-0 On September 8, 2026, through September 10, 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 five residents; five receiving services under the Assisted Living Facility license. An immediate correction order was identified on September 8, 2026, issued for SL36560016-0, tag identification 0775. During the course of the survey, the licensee took action to mitigate the imminent risk. Noncompliance remained and the scope and level remained unchanged.	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.	
0 650 SS=D	144G.42 Subd. 8 (a) Staff records	0 650		

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0 650	Continued From page 1 (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records included all required content for one of two employees (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number or residents are affected or one or a limited number of staff are involved, or the	0 650		

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0 650	Continued From page 2 situation has occurred only occasionally). The findings include: ULP-C was hired on June 15, 2022, and began providing assisted living services. ULP-C's employee record lacked documentation of an annual performance review identifying areas of improvement needed and training needs. On September 10, 2026, at 9:27 a.m., owner (O)-A stated ULP-C's record did not include an annual performance evaluation. O-A stated they did not know who was responsible for completing the annual evaluations. The licensee's Personnel Records policy dated February 4, 2025, indicated employee records would include performance evaluations identifying areas of improvement needed and training needs, and that performance reviews would be conducted at least annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis	0 660		

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0 660	Continued From page 3 Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included current information on the licensee's annual TB risk assessment and baseline screening and testing for one of two employees (unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's Facility TB Risk Assessment was completed on February 1, 2026, and indicated the facility was at low risk for TB transmission. The Facility TB Risk Assessment indicated the national rate of TB was 2.5/100,000, and the	0 660		

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0 660	Continued From page 4 Minnesota rate was 2.3/100,000. The Facility TB Risk Assessment incident rates were inaccurate compared to the annual rates reported by the Minnesota Department of Health in April 2026. ULP-D was hired on September 22, 2025, and began providing assisted living services. ULP-D's employee record included a TB symptom and history screen dated September 17, 2025, and a single tuberculin skin test (TST) result dated September 16, 2025. ULP-D's employee file lacked a second TST. On September 10, 2026, at 9:47 a.m., owner (O)-A stated ULP-D's employee record did not include a second TST and they are unable to obtain the results as ULP-D was out of town. The licensee's TB Prevention and Control policy dated February 25, 2025, indicated that upon hire all staff would be tested for TB with either a two-step TST or a single TB blood test. The policy also indicated an annual community TB risk assessment would be completed. The Facility TB Risk Assessment Instructions and Worksheet for Health Care Settings Licensed by MDH dated April 2026, indicated the following incidence for TB: -national case rate for 2025: 3.0 per 100,000 population; and -Minnesota case rate for 2025: 2.8 per 100,000 population. The Minnesota Department of Health (MDH) guidelines Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, indicated base line TB screening included the following:	0 660		

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0 660	Continued From page 5 -assessing for current symptoms of active TB disease; -assessing TB history; and -testing for the presence of infection by administering either a two-step TST or a single TB blood test. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
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	0 730		

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0 730	Continued From page 6 resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident records included documentation of services provided for two of two residents (R4, 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 potential to affect a large portion or all of the residents). The findings include:	0 730		

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0 730	Continued From page 7 R4 R4 was admitted on August 16, 2025, and began receiving assisted living services. R4's Service Plan Waiver dated September 2, 2025, indicated R4's services included assistance with dressing and grooming, behavior management, socialization, shopping assistance, and medication administration. R4's Service Recap Summary dated September 2026, lacked documentation of services provided for the following services and dates: -manage behavior, other mental health needs on September 1, 2, 3, 4, 5, 6, 7, and 8, 2026; -manage behavior, agitation on September 8, 2026; -shopping assistance on September 3, 2026; -individual socialization on September 1, 2, 3, 4, 5, 6, 7, and 8, 2026; -group socialization on September 1, 2, 3, 4, 5, 6, 7, and 8, 2026; and -bathing reminder on September 8, 2026 R5 R5 was admitted on June 30, 2026, and began receiving assisted living services. R5's Service Plan Waiver dated July 3, 2026, indicated R5's services included medication administration and safety checks. R5's Service Recap Summary dated August 2026, lacked documentation of services provided for the following services and dates: -safety checks on August 2, 13, and 23, 2026; and -medication administration on August 5, 6, and 7, 2026.	0 730		

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0 730	Continued From page 8 On September 10, 2026, at 9:27 a.m., owner (O)-A stated they were unaware that direct care staff were not documenting that services had been provided. O-A stated they were unsure whether the nurse was auditing the service logs. On September 10, 2026, at 11:09 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-B was unavailable for an interview. The licensee's undated Resident Records policy indicated resident records would include documentation that services have been provided as identified in the resident's service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
0 775 SS=I	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 and interview, the licensee failed to comply with Minnesota Fire Code, Minnesota Rules 7511. This had the potential to directly affect four residents and all staff. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident), and was	0 775	During the course of the survey, the licensee took action to mitigate the imminent risk. Noncompliance remained and the scope and level remained unchanged.	

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0 775	Continued From page 9 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: EGRESS WINDOWS OCCUPIED SLEEPING ROOMS On September 8, 2026, at 11:30 a.m., the surveyor toured the facility with owner (O)-A and unlicensed personnel (ULP)-C. The egress windows in occupied resident bedrooms were opened by O-A and ULP-C and measured by the surveyor. The egress windows in occupied resident bedrooms one, two, four, and five, did not meet the minimum requirements for safe egress. Egress window measurements: Occupied bedroom one - the clear open area of the window measured 32 inches clear width, 17 inches clear height, with a total clear area of 620 square inches. Occupied bedroom two - the clear open area of window #1 measured 36.5 inches clear width, 17.25 inches clear height, with a total clear area of 629 square inches and window #2 measured 32.5 inches clear width, 18.75 inches clear height, with a total clear area of 609 square inches. Occupied bedroom four - the height from the floor to the egress windowsill opening measured 54 inches. Occupied bedroom five - the height from the floor to the egress windowsill opening measured 53 inches. Required egress window openings in rooms of care facilities licensed or registered by the state	0 775		

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0 775	Continued From page 10 of Minnesota shall have a minimum net clear opening area of 4.5 square feet (648 square inches). Opening height and width dimensions shall not be less than 20 inches. The net clear opening dimensions shall be the result of normal operation of the opening. [Minn. Stat. 144G.45 subd. 2; MSFC 1104.26.2, 1104.26.6.1] Escape window openings shall have a maximum height from the floor to the windowsill opening shall not exceed 48 inches. Escape windows with openings up to 52 inches off of the floor may meet the height requirement for existing buildings by securing a step, platform or bed to the wall directly underneath the window. This step, platform or bed shall be no more than 44 inches below the opening and must be strong enough to support the weight of the person. The minimum acceptable width shall be the same as the window opening. The minimum acceptable depth away from the wall shall be 18 inches. [Minn. Stat. 144G.45 subd. 2; MSFC 1104.26.3, 1104.26.6.1] During the facility tour interview, O-A verified the egress window measurements. TIME PERIOD FOR CORRECTION: Immediate Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated September 8, 2026, for additional violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		

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0 780	Continued From page 11	0 780		
0 780 SS=E	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; (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, record review, and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G.	0 780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36560	A. BUILDING: _____ B. WING _____	09/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIYATHY HOUSING WITH SERVIC	10932 GETTYSBURG AVENUE NORTH 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
0 780	Continued From page 12 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated September 8, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 790 SS=E	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced	0 790		

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	36560	A. BUILDING: _____ B. WING _____	09/10/2026

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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
0 790	Continued From page 13 by: Based on observation, record review, and interview, 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 two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated September 8, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=F	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.	0 800		

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	36560	A. BUILDING: _____ B. WING _____	09/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIYATHY HOUSING WITH SERVIC	10932 GETTYSBURG AVENUE NORTH CHAMPLIN, MN 55316

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0 800	Continued From page 14 This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, 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 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 September 8, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36560	A. BUILDING: _____ B. WING _____	09/10/2026

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0 810	Continued From page 15 (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, 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 two violation (a	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIYATHY HOUSING WITH SERVIC	10932 GETTYSBURG AVENUE NORTH CHAMPLIN, MN 55316

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0 810	Continued From page 16 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 September 8, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 830 SS=F	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements, except a facility with a licensed resident capacity of six or fewer is exempt from rental licensing regulations imposed by any town, municipality, or county. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to follow applicable state and local laws, regulations, standards,	0 830		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 830	Continued From page 17 ordinances, and codes related to smoking for five of five residents (R1, R2, R3, R4, 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 potential to affect a large portion or all of the residents). The findings include: On September 8, 2026, at 10:30 a.m., during a facility tour, the surveyor observed a strong odor of cigarette smoke on the lower level of the residence outside of rooms 4 and 5. Unlicensed personnel (ULP)-C stated, "that's [R4], he knows he is not supposed to smoke in the house". ULP-C also stated all residents in the house were smokers. The surveyor also observed chairs and a smoking waste receptacle near the front door of the house. On September 9, 2026, at 1:20 p.m., the engineering specialist reported observing cigarette butts on the furniture and floors of rooms 4 and 5 on the lower level. The engineering specialist also reported residents were smoking in an area set up in the garage. On September 9, 2026, at 1:55 p.m., the surveyor observed the garage with couches, tables, and cigarette disposal receptacles in the garage. The garage door was open with a screen covering the open area. The surveyor observed R2 smoking in the garage.	0 830		

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0 830	Continued From page 18 On September 9, 2026, at 1:55 p.m., ULP-C stated the residents usually smoke in the garage during the winter. On September 10, 2026, at 11:09 a.m., owner (O)-A stated they were unaware that smoking in the garage was considered indoor smoking. O-A also stated that sometimes cigarette butts fall out of the residents' pockets. The Minnesota Clean Indoor Air Act (MCIAA) amendment updated on May 21, 2026, defined an indoor smoking area as a space between a floor and a ceiling that is at least half enclosed by walls, doorways, or windows (opened or closed) around the perimeter. A wall included retractable dividers, garage doors, plastic sheeting or any other temporary or permanent physical barrier. The MCIAA amendment updated on May 21, 2026, indicated assisted living facilities prohibit indoor smoking except in a designated separate, enclosed room maintained in accordance with applicable state and federal laws, including signage at each entrance of the facility and signage at the entrance of the designated smoking area. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) Days Engineering Citations Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated September 8, 2026, for the specific violations related the physical environment under Minnesota Statute 144G.	0 830		

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0 830	Continued From page 19 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 830		
0 860 SS=E	144G.45 Subd. 6 New construction; plans (a) For all new licensure and construction beginning on or after August 1, 2021, the following must be provided to the commissioner: (1) architectural and engineering plans and specifications for new construction must be prepared and signed by architects and engineers who are registered in Minnesota. Final working drawings and specifications for proposed construction must be submitted to the commissioner for review and approval; (2) final architectural plans and specifications must include elevations and sections through the building showing types of construction, and must indicate dimensions and assignments of rooms and areas, room finishes, door types and hardware, elevations and details of nurses' work areas, utility rooms, toilet and bathing areas, and large-scale layouts of dietary and laundry areas. Plans must show the location of fixed equipment and sections and details of elevators, chutes, and other conveying systems. Fire walls and smoke partitions must be indicated. The roof plan must show all mechanical installations. The site plan must indicate the proposed and existing buildings, topography, roadways, walks and utility service lines; and (3) final mechanical and electrical plans and specifications must address the complete layout and type of all installations, systems, and equipment to be provided. Heating plans must include heating elements, piping, thermostatic controls, pumps, tanks, heat exchangers, boilers, breeching, and accessories. Ventilation plans	0 860		

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SOURIYATHY HOUSING WITH SERVIC	10932 GETTYSBURG AVENUE NORTH CHAMPLIN, MN 55316

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0 860	Continued From page 20 must include room air quantities, ducts, fire and smoke dampers, exhaust fans, humidifiers, and air handling units. Plumbing plans must include the fixtures and equipment fixture schedule; water supply and circulating piping, pumps, tanks, riser diagrams, and building drains; the size, location, and elevation of water and sewer services; and the building fire protection systems. Electrical plans must include fixtures and equipment, receptacles, switches, power outlets, circuits, power and light panels, transformers, and service feeders. Plans must show location of nurse call signals, cable lines, fire alarm stations, and fire detectors and emergency lighting. (b) Unless construction is begun within one year after approval of the final working drawing and specifications, the drawings must be resubmitted for review and approval. (c) The commissioner must be notified within 30 days before completion of construction so that the commissioner can make arrangements for a final inspection by the commissioner. (d) At least one set of complete life safety plans, including changes resulting from remodeling or alterations, must be kept on file in the facility. (e) For new construction beginning on or after July 1, 2025, the licensee must comply with section 144.554 to submit applicable construction plans and fees to the commissioner. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, 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 two violation (a	0 860		

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0 860	Continued From page 21 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated September 8, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 860		
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by:	0 910		

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0 910	Continued From page 22 Based on interview and record review, the licensee failed to develop and execute an assisted living written contract with the required content for one of two residents (R5). 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 potential to affect a large portion or all of the residents). The findings include: R5 was admitted on June 30, 2026, and began receiving assisted living services. R5's record included a [licensee] Resident Agreement signed on July 1, 2026. The agreement (page 2, sections 1 and 2) listed an address and health facility identification number (HFID) different than the current facility. On September 10, 2026, at 10:32 a.m., owner (O)-A stated the contract was for a different facility under the same ownership. O-A stated they may use the contracts interchangeably and was unaware they could not use a contract for a facility with a different HFID. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring	01620		

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01620	Continued From page 23 (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. (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	01620		

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01620	Continued From page 24 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 interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing client monitoring and reassessment every 90 days for one of two residents (R4). 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: R4 was admitted on August 16, 2025, and began receiving assisted living services. R4's Service Plan Waiver dated September 2, 2025, indicated R4's services included assistance with dressing and grooming, behavior management, medication administration, socialization, and shopping assistance. R4's record included consecutive nursing	01620		

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01620	Continued From page 25 assessments completed on March 9, 2026, and June 8, 2026, indicating 91 days had passed between assessments. On September 10, 2026, at 10:42 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-B was unavailable for an interview. On September 10, 2026, at 10:42 a.m., owner (O)-A stated the nurse was aware of the required frequency of assessments. O-A stated they were trying to hire a second nurse to assist with assessments. The licensee's Initial and Ongoing Nursing Assessment of Residents policy dated February 18, 2025, indicated ongoing assessments would be completed periodically but no less than every 90 days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIYATHY HOUSING WITH SERVIC	10932 GETTYSBURG AVENUE NORTH 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
01650	Continued From page 26 (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident service plan included the services authorized by the Department of Health Services (DHS) Support Plan for five of five residents (R1, R2, R3, R4, 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 the residents). The findings include: R1	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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SOURIYATHY HOUSING WITH SERVIC	10932 GETTYSBURG AVENUE NORTH CHAMPLIN, MN 55316

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01650	Continued From page 27 R1 was admitted on October 3, 2025, and began receiving assisted living services. R1's record included a DHS Support Plan authorizing services from May 1, 2026, through April 30, 2027. R1's Service Plan Waiver dated October 2, 2024, indicated R1's services consisted of medication administration three times daily. R1's Service Plan Waiver lacked identification of the following services approved through the DHS Support Plan: -housekeeping and laundry; -assistance with shopping; -assistance with making appointments; -arranging and providing non-medical transportation; -meal preparation; -socialization; -assistance with bathing, grooming, and continence care; -assistance with walking and transferring; -delegated clinical monitoring; and -mental health management for wandering, orientation issues, and agitation. R2 R2 was admitted on April 2, 2025, and began receiving assisted living services. R2's record included a DHS Support Plan authorizing services from April 1, 2026, through March 31, 2027. R2's Service Plan Waiver dated April 14, 2025, indicated R2 received assistance with medication administration three times daily. R2's Service Plan Waiver lacked identification of the following services authorized in R2's support plan:	01650		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIYATHY HOUSING WITH SERVIC	10932 GETTYSBURG AVENUE NORTH CHAMPLIN, MN 55316

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01650	Continued From page 28 -assistance with housekeeping and laundry; -assistance with making appointments; -arranging non-medical transportation; -meal preparation; -assistance with dressing, grooming, bathing, continence care, eating, walking, and transferring; and -assistance with managing anxiety and self-injurious behavior; R3 R3 was admitted on February 10, 2026, and began receiving assisted living services. R3's record included a DHS Support Plan authorizing services from June 1, 2026, through May 31, 2027. R3's Service Plan Waiver dated February 28, 2026, indicated R3 received medication administration four times daily. R3's service plan lacked identification of the following services authorized under the DHS Support Plan: -housekeeping and laundry; -assistance with shopping; -assistance making appointments; -arranging and providing non-medical transportation; -meal preparation; -socialization; -assistance with dressing, bathing, continence care, walking, and transferring; -verbal or visual medication reminders and medication setups and monitoring; -therapeutic exercises; and -managing anxiety and other cognitive/mental health needs. R4 R4 was admitted on August 16, 2025, and began	01650		

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	36560	A. BUILDING: _____ B. WING _____	09/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIYATHY HOUSING WITH SERVIC	10932 GETTYSBURG AVENUE NORTH CHAMPLIN, MN 55316

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01650	Continued From page 29 receiving assisted living services. R4's record included a DHS Support Plan authorizing services from January 1, 2026, through December 31, 2026. R4's Service Plan Waiver dated September 2, 2025, indicated R4's services included assistance with making appointments, bathing, dressing, and grooming, behavior management, medication setup, shopping, and transportation. R4's service plan lacked identification of the following services authorized by R4's support plan: -laundry and housekeeping; -meal preparation; -assistance with transferring; and -delegated clinical monitoring. R5 R5 was admitted on June 30, 2026, and began receiving assisted living services. R5's record included a DHS Support Plan authorizing services from July 1, 2026, through June 30, 2026. R5's Service Plan Waiver dated July 3, 2026, indicated R5 received medication administration three times daily and safety checks 13 times daily. R5's service plan lacked identification of the following services authorized by R5's support plan: -assistance with behavior management; -shopping; -meal preparation; -medication cueing and reminders; -insulin cueing and reminders; and -money management. On September 10, 2026, at 10:42 a.m., O-A	01650		

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	36560	A. BUILDING: _____ B. WING _____	09/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIYATHY HOUSING WITH SERVIC	10932 GETTYSBURG AVENUE NORTH 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
01650	Continued From page 30 stated they were unaware all authorized services were not listed on the service plans. O-A stated their staff were still learning how to use Residex (electronic health record). O-A stated they provided the services that were not listed on the service plans. The licensee's Contents of Service Plans policy dated February 18, 2025, indicated service plans would include a description of the services provided along with the frequency of each service according to resident needs and preferences. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01700 SS=D	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent	01700		

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01700	Continued From page 31 diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management assessment to include all required content for one of two residents (R5) who received medication management services. 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: During the entrance conference on September 8, 2026, at 11:19 a.m., owner (O)-A stated the licensee provided medication management services to all the licensee's residents. R5 was admitted on June 30, 2026, and began receiving assisted living services. R5's Service Plan Waiver dated July 3, 2026,	01700		

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01700	Continued From page 32 indicated R5 received medication administration three times daily and safety checks 13 times daily. R5's Medication Administration Summary dated September 2026, indicated the following medications were administered to R5: -aripiprazole 30 milligrams (mg) on September 1, 2, 3, 4, 5, 6, 7, and 8, 2026; -empagliflozin 10 mg on September 1, 2, 3, 4, 5, 6, 7, and 8, 2026; -hydrochlorothiazide 12.5 mg on September 1, 2,3 ,4 ,5, 6, 7, and 8, 2026; -glargine insulin 25 units (u) on September 7, and 8, 2026; -loratadine 10 mg on September 1, 2, 3, 4, 5, 6, 7, and 8, 2026; -metformin 500 mg on September 1, 2, 3, 4, 5, 6, 7, and 8, 2026; -nicotine patch 21 mg on September 1, 2, and 7, 2026; -omeprazole 40 mg on September 1, 2, and 7, 2026; and -rosuvastatin 20 mg on September 1, 2, and 7, 2026. R5's record included a nursing assessment dated July 16, 2026. Under the Medications section, the assessment lacked identification of interventions needed in management of medications to precent diversion of medication by the resident or others who may have access to the medications, and instructions to the resident and legal or designated representatives o interventions to manage the resident's medications and prevent diversion of medications. On September 10, 2026, at 10:49 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-B was unavailable for an interview.	01700		

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01700	Continued From page 33 On September 10, 2026, at 10:49 a.m., owner (O)-A stated they were unaware the medication assessment for R5 was missing required content and would pass the information along to the nurse. The licensee's Medication Assessment policy dated February 25, 2025, indicated medication management assessments would include interventions to prevent medication diversion and instructions would be provided to the resident and resident's representatives on interventions to prevent diversion. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced	01760		

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01760	Continued From page 34 by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered as prescribed for one of two residents (R2) This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 was admitted on December 20, 2024, and began receiving assisted living services. R2's Service Plan Waiver signed on April 14, 2025, indicated R2 received medication administration three times daily. R2's Medication Administration Summary dated September 2026, indicated gabapentin 600 milligrams (mg) was ordered three times daily and tamsulosin 0.4 mg was ordered daily in the afternoon. On September 8, 2026, at 1:35 p.m., the surveyor observed unlicensed personnel (ULP)-C administer gabapentin 600 mg to R2. ULP-C failed to check the medication against the medication record prior to administration. On September 8, 2026, at 1:40 p.m., ULP-C stated they usually check medications prior to administration but didn't check with this dose as it	01760		

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01760	Continued From page 35 was only one medication. The surveyor observed ULP-C logging into the electronic record to document the medication had been administered. ULP-C stated they could not document the administration as it was not on the computer task list (medication record). ULP-C stated they would check with the registered nurse. On September 9, 2026, at 11:15 a.m., ULP-C stated they had given the gabapentin at the wrong time the previous day and it should have been administered later in the afternoon. ULP-C stated they had reported it to licensed assisted living director/clinical nurse supervisor (LALD/CNS)-B. On September 9, 2026, at 11:30 a.m., the surveyor observed ULP-C administering medications to R2. ULP-C checked the medications against the computerized medication record during preparation. ULP-C stated tamsulosin was in the pill pack, but not on the medication record. ULP-C stated he always gave the tamsulosin with the morning medications and administered the medication to R2. On September 10, 2026, at 9:40 a.m., LALD/CNS-B was unavailable for an interview. On September 10, 2026, at 9:40 a.m., owner (O)-A stated they were unaware that medications were administered incorrectly. O-A stated that the nurse and staff were still learning how to use the online documentation system for order entry and medication administration. The licensee's Documentation of Medication, Treatment, and Therapy Management Services policy dated February 25, 2025, indicated staff would document each task immediately after that	01760		

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01760	Continued From page 36 task had been performed and in accordance with professional standards of documentation. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for one of two residents (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: R5 was admitted on June 30, 2026, and began receiving assisted living services. R5's Service Plan Waiver signed July 3, 2026,	01820		

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01820	Continued From page 37 indicated R2's services included medication administration. R5's Medication Administration Summary dated September 2026, indicated the following medications were administered to R5: -aripiprazole 30 milligrams (mg) on September 1, 2, 3, 4, 5, 6, 7, and 8, 2026; -empagliflozin 10 mg on September 1, 2, 3, 4, 5, 6, 7, and 8, 2026; -hydrochlorothiazide 12.5 mg on September 1, 2,3 ,4 ,5, 6, 7, and 8, 2026; -glargine insulin 25 units (u) on September 7, and 8, 2026; -loratadine 10 mg on September 1, 2, 3, 4, 5, 6, 7, and 8, 2026; -metformin 500 mg on September 1, 2, 3, 4, 5, 6, 7, and 8, 2026; -nicotine patch 21 mg on September 1, 2, and 7, 2026; -omeprazole 40 mg on September 1, 2, and 7, 2026; and -rosuvastatin 20 mg on September 1, 2, and 7, 2026. R5's record lacked a current written or electronically recorded prescription for all prescribed medications that licensee was managing for the resident. On September 9, 2026, at 2:42 p.m., owner (O)-A provided surveyor with a Patient Profile dated July 7, 2026, from Genoa pharmacy. The profile lacked prescriber authentication. O-A stated they were unable to locate signed orders for R5 and would have the registered nurse "take care of that". No further information was provided.	01820		

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01820	Continued From page 38 TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01830 SS=F	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure prescriptions were renewed at least annually, or every 12 months, for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 was admitted on April 2, 2025, and began receiving assisted living services. R2's Service Plan Waiver signed April 14, 2025, indicated R2 received medication administration three times daily. R2's Medication Administration Summary dated September 2026, indicated R2 had been	01830		

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01830	Continued From page 39 administered the following medications during that month: -aspirin 81 milligrams (mg) daily; -ferrous sulfate 325 mg daily; -gabapentin 600 mg three times daily; -tamsulosin 0.4 mg daily; -atorvastatin 80 mg daily; -olanzapine 15 mg daily; and -trazadone 50 mg daily; R2's record lacked a current prescription renewal for all medications that licensee was managing for R2. On September 9, 2026, at 2:42 p.m., owner (O)-A stated they were unaware that order renewal was required annually and would have the registered nurse obtain the orders. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01830		
01940 SS=F	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;	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36560	A. BUILDING: _____ B. WING _____	09/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIYATHY HOUSING WITH SERVIC	10932 GETTYSBURG AVENUE NORTH 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
01940	Continued From page 40 (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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure current treatments were included in the service plan, and that a current individualized treatment plan included the required content for one of one resident receiving treatments (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 potential to affect a large portion or all of the residents). The findings include:	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36560	A. BUILDING: _____ B. WING _____	09/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIYATHY HOUSING WITH SERVIC	10932 GETTYSBURG AVENUE NORTH 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
01940	Continued From page 41 R5 was admitted to the licensee on June 30, 2026. R5's Service Plan Waiver dated July 3, 2026, indicated R5 received medication administration and safety checks. R5's service plan lacked documentation that R5 received blood glucose monitoring. R5's Medication Administration Summary dated September 2026, indicated R5 was to receive blood glucose monitoring three times daily. R5's Patient Profile dated July 7, 2026, from Genoa pharmacy indicated supplies were provided to licensee to monitor R5's blood glucose three times daily. R5's Treatment/Therapy Management Plan dated July 16, 2026, indicated R5 received blood glucose monitoring services. The treatment plan lacked identification of treatment or therapy tasks that would be delegated to unlicensed personnel. On September 10, 2026, at 11:01 a.m., owner (O)-A stated they were unaware that R5's service plan and treatment plan were missing required information. O-A stated they would have the registered nurse add the required information to the treatment plan. The licensee's Contents Of Service Plans policy dated February 18, 2025, indicated that service plans would include a description of services provided and the frequency of each service according to resident assessment and resident preferences. The licensee's Individualized Medication, Treatment, and Therapy Management Plans	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36560	A. BUILDING: _____ B. WING _____	09/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIYATHY HOUSING WITH SERVIC	10932 GETTYSBURG AVENUE NORTH 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
01940	Continued From page 42 policy dated February 25, 2025, indicated treatment and therapy management plans would include identification of treatment or therapy tasks that may be delegated to an unlicensed staff member. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01960 SS=F	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document treatment administration for one of one resident (R5) 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 a widespread scope (when	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36560	A. BUILDING: _____ B. WING _____	09/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIYATHY HOUSING WITH SERVIC	10932 GETTYSBURG AVENUE NORTH 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
01960	Continued From page 43 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: R5 was admitted on June 30, 2026, and began receiving assisted living services. R5's Service Plan Waiver dated July 3, 2026, indicated R5 received medication administration and safety checks. R5's service plan lacked documentation that R5 received blood glucose monitoring. R5's Medication Administration Summary dated September 2026, indicated R5 was to receive blood glucose monitoring three times daily. R5's record included a Vital Signs summary dated August 1, 2026, through September 1, 2026, which included documented results of blood glucose monitoring. R5's record lacked blood glucose monitoring results for the following dates and times: -August 3, 2026: documented as completed at 7:08 p.m., and lacking documentation of blood glucose result; -August 11, 2026: documented as completed at 12:44 p.m., and 8:26 p.m., with blood glucose result of 276 documented at 4:03 p.m.; -August 13, 2026: scheduled blood glucose checks at p.m., and bedtime lacked documentation that blood glucose was checked or reason why it was not checked along with follow up procedures to meet the residents' needs; -August 17, 2026: documented as completed at 7:17 p.m., and 8:04 p.m., with blood glucose result of 166 documented ty 10:44 a.m.;	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36560	A. BUILDING: _____ B. WING _____	09/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIYATHY HOUSING WITH SERVIC	10932 GETTYSBURG AVENUE NORTH 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
01960	Continued From page 44 -August 19, 2026: scheduled blood glucose check at bedtime lacked documentation that blood glucose was checked or reason why it was not checked along with follow up procedures to meet the resident needs; -August 19, 2026: documented as competed at 8:12 p.m., and 11:08 p.m., with one blood glucose result of 122 documented at 2:34 p.m.; and -August 20, 2026: documented as completed at 9:18 p.m., and 9:22 p.m., and lacking documentation of blood glucose results; On September 10, 2026, at 11:01 a.m., owner (O)-A stated she asked staff to check blood sugar three times each night (12:00 a.m., 3:00 a.m., and 6:00 a.m.) on any resident receiving insulin. O-A stated staff were "not doing their jobs". The licensee's Documentation of Medication, Treatment, and Therapy Management Services dated February 25, 2025, indicated staff would document each task immediately after that task was performed. No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	01960		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36560	A. BUILDING: _____ B. WING _____	09/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIYATHY HOUSING WITH SERVIC	10932 GETTYSBURG AVENUE NORTH 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
01970	Continued From page 45 renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure that up-to-date written or electronic treatment orders were maintained for one of one resident receiving treatments (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: R5 was admitted to the licensee on June 30, 2026. R5's Service Plan Waiver dated July 3, 2026, indicated R5 received medication administration and safety checks. R5's service plan lacked documentation that R5 received blood glucose monitoring. R5's Medication Administration Summary dated September 2026, indicated R5 was to receive blood glucose monitoring three times daily. R5's Patient Profile dated July 7, 2026, from Genoa pharmacy indicated supplies were provided to licensee to monitor R5's blood glucose three times daily.	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36560	A. BUILDING: _____ B. WING _____	09/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIYATHY HOUSING WITH SERVIC	10932 GETTYSBURG AVENUE NORTH 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
01970	Continued From page 46 R5's record lacked a written or electronically recorded order from an authorized prescriber for blood glucose management. On September 9, 2026, at 2:42 p.m., owner (O)-A stated they were unable to locate admission orders for R5 and would have the registered nurse look for the orders. Treatment orders for R5 were not received prior to concluding the survey on September 10, 2026, at 3:23 p.m. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

SOURIYATHAY ENTERPRISES LLC
10932 GETTYSBURG AVENUE NORTH
Champlin, MN 55316
Hennepin County
Parcel:

Phone:

License Info

License: HFID 36560

Risk:
License:
Expires on:
CFPM: PHINHSAYKEO
SOURIYATHAY
CFPM #: FM121990; Exp: 03/19/2027

Inspection Info

Report Number: F8087261223
Inspection Type: Full - Single
Date: 9/9/2026 Time: 9:30:00 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

THIS WAS AN ANNOUNCED AND SCHEDULED FULL INSPECTION.

INSPECTION CONDUCTED IN THE PRESENCE OF HRD NURSE EVALUATOR.

THE FOLLOWING OBSERVATIONS WERE MADE:

CEILING: POPCORN STYLE, TEXTURED, DOES NOT APPEAR TO BE DURABLE - NON COMPLIANT
FLOORS: HARDWOOD - COMPLIANT
COUNTERTOPS: QUARTZ - NON COMPLIANT
CABINETS: WOOD - NON COMPLIANT
REFRIGERATOR/FREEZER: WHIRLPOOL
DISHWASHER: SHARP
STOVE/RANGE: KENMORE
MICROWAVE: WHIRLPOOL
HAND WASHING SINK: YES - RIGHT SIDE OF 2-BIN COMPOSITE STEEL KITCHEN SINK

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

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

HOT WATER TEMPERATURE AT THE KITCHEN SINK REACHED 120 DEGREES.

INSPECTION REPORT EMAILED TO FACILITY AND HRD NURSE SURVEYOR.

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Metro District Office inspection report number F8087261223 from 9/9/2026

John Boettcher

PHINHSAYKEO SOURIYATHAY
OWNER

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

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

Temperature Observations/Recordings

Establishment Info

SOURIYATHAY ENTERPRISES LLC
Champlin
County/Group: Hennepin County

Inspection Info

Report Number: F8087261223
Inspection Type: Full
Date: 9/9/2026
Time: 9:30:00 AM

Equipment Temperature: Product/Item/Unit: AMBIENT AIR**; Temperature Process:** Ambient Air
Location: Upright Freezer at -8 Degrees F.
Comment:
Violation Issued?: No

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

Food Temperature: Product/Item/Unit: MILK **; Temperature Process:** Cold-Holding
Location: Upright Cooler at 39 Degrees F.
Comment:
Violation Issued?: No

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

Food Temperature: Product/Item/Unit: YOGURT**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 39 Degrees F.
Comment:
Violation Issued?: No

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL36560016-0	**Date:** September 8, 2026
Facility Name: Souriyathay Enterprises LLC	
Facility Address: 10932 Gettysburg Avenue North, Champlin, MN 55316	

☒ **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. Occupancy separation shall be provided in Group I and Group R occupancies. Existing wood lath and plaster in good condition or ½ inch gypsum wallboard is acceptable where one hour occupancy separations are required. [Minn. Stat. 144G.45 subd. 2; MSFC 1105.2]

   Comments: There was a hole in the wall between the attached garage and the dwelling unit, and the garage was used for the storage of combustible items. This hole shall be sealed to prevent the passage of smoke or fire from the garage into the dwelling unit.

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

   Comments:
   - In occupied resident bedrooms one and four, the egress windows were obstructed by the storage of personal belongings in front of the windows.
   - The area under the stairs was used for the storage of combustible items.

4. Escape window openings shall have a maximum height from the floor to the windowsill opening shall not exceed 48 inches. Per SFMD Policy, Escape windows with openings up to 52 inches off of the floor may meet the height requirement for existing buildings by securing a step, platform or bed to the wall directly underneath the window. This step, platform or bed shall be no more than 44 inches below the opening and must be strong enough to support the weight of the person. The minimum acceptable

width shall be the same as the window opening. The minimum acceptable depth away from the wall shall be 18 inches. [Minn. Stat. 144G.45 subd. 2; MSFC 1104.26.3, 1104.26.6.1]

Comments: A window well style ladder and a decorative bar were installed under the egress windows inside resident bedrooms four and five. The ladder and decorative bar attached to the walls did not meet the requirements for a step or platform per SFMD Policy.

5. Lighted matches, cigarettes, cigars or other burning objects shall not be discarded in such a manner that could cause ignition of other combustible material. [Minn. Stat. 144G.45 subd. 2; MSFC 310.7]

   Comments:
   - Plastic bags were used inside the containers designated for smoking material disposal.
   - Several burnt cigarettes had been discarded on the floor inside resident bedroom five.
   - One burnt cigarette had been discarded on a shelving unit inside resident bedroom four.

6. Open junction boxes and open-wiring splices shall be prohibited. Approved covers shall be provided for all switch and electrical outlet boxes. [Minn. Stat. 144G.45 subd. 2; MSFC 604.6]

   Comments:
   - There was an uncovered electrical junction box with capped wires in the locked basement storage area under the stairs.
   - On the exterior deck, the top half of the weatherproof cover was missing from one electrical wall outlet.

7. 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: Two power strips were daisy chained together in the attached garage.

8. 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: A multiplug adapter was used for personal electronics in occupied resident bedroom four.

9. Single- and multiple-station smoke alarms shall be replaced when they fail to respond to operability tests or exceed ten years from the date of manufacture. Smoke alarms shall be replaced with smoke alarms having the same type of power supply. [Minn. Stat. 144G.45 subd. 2; MSFC 1103.8.1]

   Comments: The hardwired smoke alarm outside new resident bedroom three was removed from the bracket. M 08 95 was date stamped on the back, indicating this smoke alarm was more than ten years from date of manufacture.

☒ **TAG IDENTIFICATION: 0780**

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

1. 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 smoke alarms installed in the basement and outside new resident bedroom three were not actuated when the hardwired interconnected smoke alarm system was tested. These smoke alarms were not interconnected.
   - The licensee stated new hardwired smoke alarms had been installed to meet the statute requirements. When the licensee tested the hardwired smoke alarm system, there were multiple extra battery operated smoke alarms installed in the building that were not actuated. All dwelling unit smoke alarms were not interconnected.

☒ **TAG IDENTIFICATION: 0790**

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

1. Portable fire extinguishers installed and maintained to MN State Fire Code. [Minn. Stat. 144G.45 subd.2]

   Comments:
   - The bottom of the portable fire extinguishers installed in the facility were date stamped 2024. These fire extinguishers lacked service tags, indicating annual maintenance had not been performed by certified service personnel in the last year.
   - There was a 1-A:10-B:C fire extinguisher stored on a wall shelf in the basement. The licensee stated this was an old extinguisher and would be removed.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) 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 occupied resident bedroom one, the door frame was soiled and there was an unsealed patched hole in the wall behind the door.
- In the main floor shared resident bathroom, several ceramic floor tiles were cracked, and the exhaust vent cover was heavily soiled.
- There were soiled surfaces between the bathtub and wall/floor junctions in the bathroom for new resident bedroom three.
- There was a loose taped electrical wall outlet in the basement storage room.
- The knob was missing from one of the hall closets on the main floor, making it difficult to open.
- There were holes and areas of crumbing asphalt on the driveway surface, creating a trip/fall hazard.
- There were several sections of deteriorated wood trim on the exterior of the building.
- An egress window had been recently installed in new resident bedroom three. There were gaps between the window and the siding on the exterior of the building.
- Standing water had accumulated on the floor of the attached garage. The licensee stated this was from a recent heavy rain and had leaked in from under the back door.
- The backyard and space under the deck were used for storage, creating an environment for pest harborage.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Twenty One (21) days

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1. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that are readily available at all times within the facility. [Minn. Stat. 144G.45 subd.2]

   Comments: The surveyor requested a copy of the fire safety and evacuation plan (FSEP) from owner (O)-A. The provided blue emergency binder included inaccurate fire safety procedure. When the surveyor discussed these inaccurate procedures with 0-A, O-A stated a site specific FSEP had been created but they were unable to locate a printed copy and would email this FESP to the surveyor. The site specific FSEP was not maintained as readily available to all building occupants and emergency responders.

2. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include the location and number of resident rooms. [Minn. Stat. 144G.45 subd.2]

   Comments:
   - Occupied resident bedroom three on the back of the building was labeled as an office on the floor plans displayed in the building. The licensee stated this room had recently been renovated from an office into a resident bedroom.

- The floor plans inaccurately identified bedroom three as being adjacent to bedrooms one and two. The licensee stated the room identified as bedroom three on the floor plans was now used as a meeting space for families and was no longer a bedroom.
Resident bedrooms need to be accurately identified on the evacuation floor plans to provide efficient communication for exiting in the event of a fire or similar emergency.

3. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include employee actions to be taken in the event of a fire or similar emergency. [Minn. Stat. 144G.45 subd.2]

   Comments: The licensee failed to develop all parts of the fire safety and evacuation plan (FSEP) with site specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The surveyor requested a copy of the fire safety and evacuation plan (FSEP) from owner (O)-A. The provided blue emergency binder included fire safety procedures that inaccurately referenced smoke compartment doors, a fire sprinkler system, and fire doors on magnetic door holders.

4. Employees of assisted living facilities shall receive training on the fire safety and evacuation plans (FSEP) upon hiring and at least twice per year thereafter. [Minn. Stat. 144G.45 subd.2]

   Comments: The surveyor requested records for employee fire safety and evacuation plan training completed in the last year from the licensee. Record review of the available documentation indicated employees completed site specific FSEP training on September 2, 2026. Employee training on the FSEP was not completed at the required frequency of at least twice per year.

5. Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. [Minn. Stat. 144G.45 subd.2]

   Comments: The surveyor requested records for resident training on the fire safety and evacuation completed in the last year. The records were not provided when requested. The licensee stated residents were trained during fire drills. Resident training was not completed at the required frequency of at least once per year.

6. Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. [Minn. Stat. 144G.45 subd.2]

   Comments: The surveyor requested records for evacuation drills completed for the past year from the licensee. Fire drill logs were provided for 2025 and 2026, indicating drills were completed in May and September 2026 and in February and April of 2025. The evacuation drill frequency was not met.

Additionally, the September 2026 drill record indicated day and night shifts were inappropriately combined.

☒ **TAG IDENTIFICATION: 0830**

SCOPE/ SEVERITY: Level 2; Pattern **TIME PERIOD OF CORRECTION:** Twenty One (21) days

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1. Facility complies with all state and local governing laws, and codes for fire safety, building, and zoning requirements. [Minn. Stat. 144G.45 subd.3]

   Comments: During the building tour, the licensee stated a new egress window had been installed approximately two months ago when renovating the office into a resident bedroom. The licensee stated they did not know if a building permit had been obtained from the city for this project.

☒ **TAG IDENTIFICATION: 0860**

SCOPE/ SEVERITY: Level 2; Pattern **TIME PERIOD OF CORRECTION:** Twenty One (21) days

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1. For all new licensure and/or construction, plans and specifications for including, but not limited to architectural, mechanical, electrical, plumbing, fire suppression, and fire alarm must be prepared and signed by architects and engineers who are registered in Minnesota. Final working drawings and specifications for proposed construction must be submitted to the commissioner for review and approval. [Minn. Stat. 144G.45 subd.6]

   Comments: The licensee failed to submit architectural and engineering plans for the addition of a resident bedroom and installation of a new egress window, in their state licensed facility to the Minnesota Department of Health (MDH) for review and approval as required.

   The licensee failed to notify MDH 30 days prior to completion of the project to allow scheduling of a final inspection. MDH was not able to verify compliance with life-safety and construction requirements before a resident occupied the space.