Electronically Delivered

October 26, 2026

Licensee
Goshen Care LLC
6330 Jefferson Street Northeast
Fridley, MN 55432

RE: Project Number(s) SL41547015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial survey on September 18, 2026, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

St - 0 - 0110 - 144g.10 Subdivision 1a - Assisted Living Director License Required - $500.00
St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - $500.00

The total amount you are assessed is $1,000.00. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per 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 residents/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 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 the Department of Health 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 MDH 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,

Kelly Thorson

Kelly Thorson, Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41547	A. BUILDING: _____ B. WING _____	09/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOSHEN CARE LLC	6330 JEFFERSON ST NE FRIDLEY, MN 55432

(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: SL41547015-0 On September 14, 2026, through September 16, 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 three resident(s); three receiving services under the Assisted Living Facility provisional license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute oMinnesota Department of Health is documenting the State Correction Orders using federal software. Tag ut 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.	

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0 110	Continued From page 1	0 110		
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an assisted living director who is licensed or permitted by the Board of Executives for Long Term Services and Supports and affiliated as the director of record with the board. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure assisted living director in residence /registered nurse (ALDIR/RN)-A was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 14, 2026, the Minnesota Board of Executives for Long-Term Services and Support (BELTSS) website indicated the healthcare facility identification number (HFID) did not have a licensed assisted living director (LALD). On September 14, 2026, at 10:00 a.m., ALDIR/RN-A stated he was contacted by BELTSS	0 110		

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0 110	Continued From page 2 due to the LALD listed on the application was unable to be director of record at this facility due to already being listed as the director of record for five other facilities. ALDIR/RN-A stated his application was in process and he was waiting on his background to clear through BELTSS and as soon as this is completed he should be listed as the director of record. The licensee's Shared Assisted Living Director and Delegation of Authority policy dated August 1, 2021, indicated an assisted living director is the person who administers, manages, supervises, or is in general administrative charge of an assisted living facility. Only an individual who is qualified as a licensed assisted living director and who holds a valid license for the current licensure. May use the title "Licensed Assisted Living Director". Within 15 days after assuming the position, the shared LALD will apply to serve as a shared director to BELTSS following directions provided by the board. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a	0 480		

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0 480	Continued From page 3 certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and	0 480		

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0 480	Continued From page 4 (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated September 15, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a	0 660		

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0 660	Continued From page 5 comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included baseline TB 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee's Facility TB Risk Assessment form was completed August 1, 2026, and identified the	0 660		

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0 660	Continued From page 6 facility TB risk level as low. ULP-D was hired on February 25, 2026, to provide direct care services to the residents. ULP-D's employee record included a TB history and symptom screen completed on April 3, 2026, and a negative TB blood test dated May 21, 2025, ULP-D's TB blood test was completed more than 90 days before their date of hire. On September 16, 2026, at 9:15 a.m., clinical nurse supervisor (CNS)-B stated he agreed the TB test for ULP-D was more than 90 days prior to her hire date and would not be in compliance with the statute requirements and he did not realize the test would need to be redone if it was more than 90 days prior to hire. The MDH guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, indicated an employee may begin working with patients with a negative TB history and symptom screen (no symptoms of active TB disease) and a negative serum blood test or the first tuberculin skin test (TST) dated within 90 days before hire. The licensee's Tuberculosis Screening/Prevention policy dated January 31, 2024, indicated baseline testing is completed on hire for all direct care provider and anyone who visits residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		

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0 800	Continued From page 7	0 800		
0 800 SS=C	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated September 15, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) Days	0 800		

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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: (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, interview, and record	0 810		

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0 810	Continued From page 9 review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level 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 15, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) Days	0 810		
01750 SS=F	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and	01750		

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01750	Continued From page 10 (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure delegated procedures were followed for one of one resident (R2) observed during medication administration. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 was admitted to the licensee on August 18, 2026, with diagnoses which included type two diabetes, schizoaffective disorder, alcohol abuse and obesity. R2's service plan dated August 18, 2026, indicated R2's services included medication administration. R2's signed provider orders dated August 31, 2026, included the following order: - Xultophy (combination medication for diabetes) 100 units/milliliter (mL)/3.6 milligram (mg)/mL, inject 26 units subcutaneously daily. R2's medication administration record (MAR) dated September 2026, included the following orders:	01750		

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01750	Continued From page 11 - Xultophy (combination medication for diabetes) 100 units/milliliter (mL)/3.6 milligram (mg)/mL, inject 26 units subcutaneously daily. On September 15, 2026, at 8:20 a.m., the surveyor observed unlicensed personnel (ULP)-C prepare R2's Xultophy pen for administration. ULP-C removed the cap, applied the needle, dialed the pen to 26 units and injected the medication into R2's upper left posterior arm. ULP-C stated he was taught to clean the pen before applying the needle and to prime the pen with two (2) units prior to dialing the dose and injecting the medication, but he was nervous due to being watched and forgot some steps. On September 15, 2026, at 8:30 a.m., clinical nurse supervisor (CNS)-B stated he teaches the staff to clean the pen with an alcohol wipe prior to applying the needle and to prime the pen with two (2) units prior to dialing the required dose before injecting the medication. CNS-B agreed this would be a breach in medication administration procedure. The manufacturer's guidelines for Xultophy dated October 2025, indicated: Instructions For Use: Step 1: Pull pen cap straight off No further information was provided. Step 2: Check the liquid in the pen. XULTOPHY® 100/3.6 should look clear and colorless. Do not use it if it looks cloudy or colored. Step 3: Select a new needle. Pull off the paper tab from the outer needle cap. Step 4: Push the capped needle straight onto the pen and twist the needle on until it is tight Step 5: Pull off the outer needle cap. Do not throw it away Step 6: Pull off the inner needle cap and throw it	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41547	A. BUILDING: _____ B. WING _____	09/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01750	Continued From page 12 away. Priming your XULTOPHY® 100/3.6 pen. Step 7: Turn the dose selector to select the priming symbol (.. -). Step 8: Hold the pen with the needle pointing up. Tap the top of the pen gently a few times to let any air bubbles rise to the top. Step 9: Hold the pen with the needle pointing up. Press and hold in the dose button until the dose counter shows "0". The "0" must line up with the dose pointer. A drop of XULTOPHY® 100/3.6 should be seen at the needle tip. If you do not see a drop of XULTOPHY® 100/3.6, repeat steps 7 to 9, no more than 6 times, until a drop of XULTOPHY® 100/3.6 appears at the needle tip. If you still do not see a drop of XULTOPHY® 100/3.6, change the needle and repeat steps 7 to 9. The licensee's Medication Administration policy dated January 31, 2024, indicated Residents of licensee are entitled to the safe administration of medications by qualified personnel according to a written medication management plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01760 SS=D	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	01760		

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01760	Continued From page 13 and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were transcribed as prescribed for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted to the licensee on August 18, 2026, with diagnoses which included type two diabetes, schizoaffective disorder, alcohol abuse and obesity. R2's service plan dated August 18, 2026, indicated R2's services included medication administration. R2's provider orders dated August 31, 2026, included the following orders: - D/C (discontinue) Tab-a-Vite (daily	01760		

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01760	Continued From page 14 multi-vitamin), take one tablet by mouth daily; and - D/C hydroxyzine HCL 25 milligram (mg) tablet, take one tablet by mouth every four (4) hours as needed for itching. R2's medication administration record (MAR) dated September 2026, included the following medications: - Tab-a-Vite (daily multi-vitamin), take one tablet by mouth daily; and - hydroxyzine HCL 25 mg tablet, take one tablet by mouth every four (4) hours as needed for itching. On September 16, 2026, at 9:20 a.m., clinical nurse supervisor (CNS)-B stated he agreed the provider orders indicate to discontinue both medications and both medications are still listed on R2's MAR. CNS-B stated he agreed this would be a transcription error on his part and must have missed these when reconciling the current medications with the orders. The licensee's Medication Orders policy, dated January 31, 2024, indicated when a written or electronic prescription is received, it must be communicated to the registered nurse in charge and recorded or placed into the resident's clinical record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all	01880		

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	41547	A. BUILDING: _____ B. WING _____	09/18/2026

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01880	Continued From page 15 prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prescription medications were securely locked in a substantially constructed compartment and permitted only authorized personnel to have access. 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 14, 2026, at 11:30 a.m., the surveyor observed a temperature log on the refrigerator located in the licensee's kitchen. Clinical nurse supervisor (CNS)-B stated the temperature log is for the unopened injectable pens that are stored in the drawer of the refrigerator and proceeded to open the door of the refrigerator and showed the surveyor the unlocked drawer which contained 3 unopened Xultophy (combination medication for diabetes) pens for R2. CNS-B stated he agreed the pens are not locked and secured so any of the residents could get access to the medications.	01880		

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01880	Continued From page 16 The licensee's Storage/Control of Medications policy dated January 31, 2024, indicated when the licensee is providing storage of medication outside of the resident's private living space, all prescription drugs are securely locked in substantially constructed compartments according to the manufacturer's directions. Only authorized personnel have access to the stored medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to date time-sensitive medications with an opened or expired date for one of one resident (R2) and the licensee failed to discard expired medications for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	01890		

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01890	Continued From page 17 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On September 14, 2026, at 1:50 p.m., the surveyor and unlicensed personnel (ULP)-C reviewed the contents of the locked medication cabinet which included the following: - R2's Xultophy (combination medication for diabetes) 100 units/milliliter (mL)/3.6 milligram (mg)/mL pen lacked an opened or expired date; and - R2's hydroxyzine HCL 25 mg tablets expired on April 28, 2026. On September 14, 2026, at 2:00 p.m., ULP-C confirmed the Xultophy pen did not have an open date on it, but he opened it last week and just forgot to put the sticker on it with the open date. ULP-C stated R2's medications came from her previous facility and confirmed the hydroxyzine had an expiration date of April 28, 2026. On September 14, 2026, at 2:10 p.m., assisted living director in residence/registered nurse (ALDIR/RN)-A stated he would expect the staff to put an open date on the insulin pens. ALDIR/RN-A confirmed hydroxyzine had an expiration date of April 28, 2026, stated R2's medications came from a previous facility, and agreed the nurse would be responsible for making sure an open date was indicated on the insulin pens and making sure the medications are not expired. The manufacturer's guidelines for Xultophy dated October 2025, indicated the pen you are using	01890		

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01890	Continued From page 18 should be thrown away after 21 days, even if it still has medication in it. The licensee's Storage/Control of Medications policy, dated January 31, 2024, indicated the licensed nurse is responsible for dating time-sensitive medications when opened. The licensee's Medication Administration policy dated January 31, 2024, Indicated the licensed nurse is responsible for assessing medications to assure that all medications are current and ordered by the prescriber and to identify any expired or outdated medications, which will be disposed according to policy. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

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

Goshen Care LLC
6330 Jefferson Street NE
Fridley, MN 55432
Anoka County
Parcel:

Phone:

License Info

License: HFID 41547

Risk:
License:
Expires on:
CFPM: Dieudonne Mukete
CFPM #: 61089; Exp: 8/27/2028

Inspection Info

Report Number: F1025261219
Inspection Type: Full - Single
Date: 9/15/2026 Time: 11:00 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 1
Total Priority 2 Orders: 0
Total Priority 3 Orders: 1
Delivery:

New Order: 4-300 Equipment Numbers and Capacities
4-301.12C *Priority Level: Priority 3 CFP#: 48*
MN Rule 4626.0680C Receptacles that substitute for the compartments of a multicompartment sink may be used as alternative manual warewashing equipment if approved.
COMMENT: Until a dishwasher with an NSF 184 Residential Sanitize cycle or a 3 compartment sink are provided, use a basin filled with a sanitizing solution (e.g. 50 - 100 PPM chlorine) to sanitize utensils once they have been cleaned in the dishwasher. Provide spec sheet/model number of a dishwasher prior to purchase to this department.
Comply By: 9/15/2026 Originally Issued On: 9/15/2026

! **New Order: 4-700 Sanitizing Equipment and Utensils**
4-702.11 *Priority Level: Priority 1 CFP#: 16*
MN Rule 4626.0900 Sanitize utensils and food contact surfaces of equipment before use, after cleaning.
COMMENT: Dishwasher does not have an NSF Residential Sanitize option. Provide a means of sanitizing utensils and dishware in the establishment.
Comply By: 9/15/2026 Originally Issued On: 9/15/2026

Food & Beverage General Comment

Residential finishes. Solid surface counters, two compartment sink, LVT floors. TMD for food and dishwasher provided.

Discussed MN 4626.0506 for cook/serve and equipment reqs, handwashing and hygiene in the kitchen, pest control, food source and recalls, food storage and date marking, cook temperatures, durable cooking equipment, CFPM renewal process.

Dishwasher Avana adb1400ams1 - Owner's Manual and product listing specifications did not specify the unit has an NSF Residential 184 Sanitize cycle. Until a dishwasher is provided which has this specifiifcation and can achieve sanitization (Per MN 4626.0020 Subp 75), sanitize clean dishes and utensils by submerging in a sanitizing solution, e.g. 1 gal of water to 1 tea of bleach.
https://www.health.state.mn.us/communities/environment/food/docs/fs/cleansanfs.pdf

Before purchasing a replacement dishwasher, send link or product specs (model #) to casey.kipping@state.mn.us

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 F1025261219 from 9/15/2026

Establishment Representative

Casey Kipping, MA RS
Public Health Sanitarian 3
651-201-4513
casey.kipping@state.mn.us

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL41547015-0	**Date:** September 15, 2026
Facility Name: GOSHEN CARE LLC	
Facility Address: 6330 Jefferson Street NE Fridley MN 55432	

☒ **TAG IDENTIFICATION: 0800**

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

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

   Comments: The main level bathroom exhaust fan was not operational.

☒ **TAG IDENTIFICATION: 0810**

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

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 lower-level evacuation plan identified an office in the lower level. That room was being used as an unoccupied resident room 5. Evacuation plans must be correctly labeled to correspond with the layout and function of the facility to provide efficient communication for exiting in the event of a fire or similar emergency.

2. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include fire protection procedures necessary for residents. [Minn. Stat. 144G.45 subd.2]

   Comments: No resident fire policy was in place or able to be provided at the time of the survey.