Electronically Delivered

October 22, 2026

Licensee
Goodhue Living
108 County 9 Boulevard
Goodhue, MN 55027

RE: Project Number(s) SL39127016

Dear Licensee:

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

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

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

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

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00
St - 0 - 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 $1,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

factor.

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

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

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

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

If you have any questions, please contact me.

Sincerely,

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

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39127	A. BUILDING: _____ B. WING _____	09/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOODHUE LIVING	108 COUNTY 9 BOULEVARD GOODHUE, MN 55027

(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: SL39127016-0 On September 21, 2026, through September 22, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 42 residents; 39 receiving services under the Assisted Living with Dementia Care Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute 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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0 480	Continued From page 1	0 480		
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 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;	0 480		

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0 480	Continued From page 2 (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 (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) 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, Food and Beverage Establishment Inspection Report (FBEIR) dated September 21, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee	0 480		

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0 480	Continued From page 3 within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota 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 21, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7)	0 775		

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0 775	Continued From page 4 days.	0 775		
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.	0 810		

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0 810	Continued From page 5 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 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 21, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan	01620		

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01620	Continued From page 6 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 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	01620		

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01620	Continued From page 7 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 timely ongoing nursing assessments for one of three residents (R1). 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: R1 was admitted on June 4, 2026, with diagnoses that included diabetes. R1's service plan dated July 21, 2026, indicated R1 received services to include bathing, escort/mobility assistance, blood glucose checks and medication administration. R1's ongoing nursing assessments dated June 9, 2026, June 26, 2026, July 17, 2026, and September 18, 2026, were reviewed. The June 26, 2026, assessment was completed 17 days after the previous assessment, thus exceeding the required reassessment at 14 calendar days. On September 22, 2026, at 9:48 a.m., assisted living director in residency/clinical nurse supervisor (ALDIR/CNS)-A stated R1's June 26,	01620		

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01620	Continued From page 8 2026, was completed late. The licensee's Assessments, Reviews and Monitoring policy dated August 1, 2022, indicated resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications;	01730		

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01730	Continued From page 9 (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized medication management plan with the required content for one of three residents (R1). 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	01730		

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01730	Continued From page 10 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on September 21, 2026, at approximately 9:10 a.m., assisted living director in residency/clinical nurse supervisor (ALDIR/CNS)-A stated the licensee provided medication management services to their residents at the facility. ALDIR/CNS-A stated medications were stored in a medication cart and medications that required refrigeration were stored in a locked refrigerator in the medication room. R1 was admitted on June 4, 2026, with diagnoses that included diabetes. R1's service plan dated July 21, 2026, indicated R1 received services to include medication administration. On September 21, 2026, at 11:29 a.m., the surveyor observed unlicensed personnel (ULP)-C check R1's blood sugar and administer insulin to R1. R1's medication administration record (MAR) dated September 2026, included the following: -Novolog Flexpen 100 units/milliliter (ml); inject 12 units subcutaneously three times daily before meals -Mounjaro Injection 5 milligrams (mg)/0.5; inject 5 mg subcutaneously once weekly R1's individualized medication management plan dated September 18, 2026, indicated the following: -Secured storage of controlled medications,	01730		

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01730	Continued From page 11 specify: Secured in locked medication cart. Double locked -Secure storage of all other medications, specify: Secured in locked medication cart. R1's medication management plan did not include refrigeration storage for R1's insulin. On September 22, 2026, at 9:49 a.m., assisted living director in residency/clinical nurse supervisor (ALDIR/CNS)-A stated insulin was stored in the refrigerator in the medication room until opened for use. ALDIR/CNS-A reviewed R1's medication management plan and stated it did not include refrigeration storage for R1's insulin. The licensee's Medication Management Individualized Plan policy dated August 1, 2021, indicated the licensee will develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: a. a statement describing the medication management services that will be provided b. a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions c. documentation of specific resident instructions relating to the administration of medications d. identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis e. identification of medication management tasks that may be delegated to unlicensed personnel f. procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services, and	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39127	A. BUILDING: _____ B. WING _____	09/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOODHUE LIVING	108 COUNTY 9 BOULEVARD GOODHUE, MN 55027

(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
01730	Continued From page 12 g. any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01750 SS=D	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 (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 one of two unlicensed personnel (ULP-C) completed insulin administration via a prefilled insulin pen according to manufacturer instructions for observed during insulin administration. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39127	A. BUILDING: _____ B. WING _____	09/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOODHUE LIVING	108 COUNTY 9 BOULEVARD GOODHUE, MN 55027

(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
01750	Continued From page 13 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: R1 was admitted on June 4, 2026, with diagnoses that included diabetes. R1's service plan dated July 21, 2026, indicated R1 received services to include medication administration. R1's medication administration record (MAR) dated September 2026, included the following: -Novolog Flexpen 100 units/milliliter (ml); inject 12 units subcutaneously three times daily before meals On September 21, 2026, at 11:29 a.m., the surveyor observed ULP-C prepare R1's Novolog insulin pen and dialed the pen to the prescribed 12 units without priming the pen first. ULP-C then administered the insulin into R1's abdomen. On September 22, 2026, at 9:52 a.m., assisted living director in residency/clinical nurse supervisor (ALDIR/CNS)-A stated she expected the ULP to prime the insulin pen with two units prior to dialing the prescribed dose. The manufacturer instructions for use for the Novolog insulin pen dated February 2023, indicated the following: A. Pull off the pen cap. Wipe the rubber stopper with an alcohol swab.	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39127	A. BUILDING: _____ B. WING _____	09/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOODHUE LIVING	108 COUNTY 9 BOULEVARD GOODHUE, MN 55027

(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
01750	Continued From page 14 B. Attaching the needle: Remove the protective tab from disposable needle. Screw the needle tightly onto your insulin pen. C. Pull off the big outer needle cap D. Pull off the inner needle cap and throw it away E. Turn the dose selector to select 2 units F. Hold your Novolog pen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge. G. Keep the needle pointing upwards, press the push-button all the way in. The dose selector returns to zero. A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure no more than six times. H. Turn the dose selector to the number of units you need to inject. The pointer should line up with your dose. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided;	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39127	A. BUILDING: _____ B. WING _____	09/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOODHUE LIVING	108 COUNTY 9 BOULEVARD GOODHUE, MN 55027

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01940	Continued From page 15 (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 observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of three residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3 was admitted on February 1, 2026, with	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39127	A. BUILDING: _____ B. WING _____	09/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOODHUE LIVING	108 COUNTY 9 BOULEVARD GOODHUE, MN 55027

(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 16 diagnoses that included Alzheimer's disease. R3's service plan dated September 18, 2026, indicated R3 received services to include activity assistance, grooming, dressing, bathing, incontinence care, skin care (heel boots on at bedtime), drinking assistance, meal assistance, escort/mobility assistance, transfer assistance, repositioning, behavior management, and medication management. On September 22, 2026, at 6:38 a.m., the surveyor observed unlicensed personnel (ULP)-E administer medications to R3. The surveyor noted two heel protector boots on a chair near R3's bed. ULP-E stated R3 wore the heel protectors when in bed. R3's service recap summary dated September 2026, included the following: -Skin Care: please put on heel boots at bedtime R3's record lacked signed prescriber orders for heel protectors. R3's record lacked a treatment management plan to include the following required content: - statement of the type of service that will be provided; - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that will be delegated to unlicensed personnel; - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and - any resident-specific requirements relating to documentation of treatment and therapy received,	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39127	A. BUILDING: _____ B. WING _____	09/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOODHUE LIVING	108 COUNTY 9 BOULEVARD GOODHUE, MN 55027

(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 17 verification that all treatment and therapy was administered as prescribed and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On September 22, 2026, at 9:47 a.m., assisted living director in residency/clinical nurse supervisor (ALDIR/CNS)-A reviewed R3's record and stated it lacked a treatment management plan to include the required content as noted above. The licensee's Treatment and Therapy Management Plan dated August 1, 2021, indicated the licensee will develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: a. a statement of the type of services that will be provided b. documentation of specific resident instructions relating to the treatments or therapy administration c. identification of treatment or therapy tasks that will be delegated to unlicensed personnel d. procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services e. any resident-specific requirements relating to documentation of treatments and therapy received f. verification that all treatment and therapy was administered as prescribed g. monitoring of treatment or therapy to prevent possible complications or adverse reactions No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39127	A. BUILDING: _____ B. WING _____	09/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOODHUE LIVING	108 COUNTY 9 BOULEVARD GOODHUE, MN 55027

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01940	Continued From page 18 days	01940		
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 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 up-to-date written or electronically recorded orders were maintained for one of three residents (R3) receiving treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3 was admitted on February 1, 2026, with diagnoses that included Alzheimer's disease. R3's service plan dated September 18, 2026, indicated R3 received services to include activity	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39127	A. BUILDING: _____ B. WING _____	09/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOODHUE LIVING	108 COUNTY 9 BOULEVARD GOODHUE, MN 55027

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01970	Continued From page 19 assistance, grooming, dressing, bathing, incontinence care, skin care (heel boots on at bedtime), drinking assistance, meal assistance, escort/mobility assistance, transfer assistance, repositioning, behavior management, and medication management. On September 22, 2026, at 6:38 a.m., the surveyor observed unlicensed personnel (ULP)-E administer medications to R3. The surveyor noted two heel protector boots on a chair near R3's bed. ULP-E stated R3 wore the heel protectors when in bed. R3's record lacked signed prescriber orders for heel protectors. On September 22, 2026, at 8:21 a.m., assisted living director in residency/clinical nurse supervisor (ALDIR/CNS)-A stated she could not locate prescriber orders for R3's heel protectors and contacted hospice (end of life care agency) to see if they had an order on file. On September 22, 2026, at 9:47 a.m., ALDIR/CNS-A stated hospice faxed the order for R3's heel protectors. The order provided for R3's heel protectors was dated September 22, 2026, which was obtained after the start of survey. The licensee's Medication and Treatment Orders-Receiving policy dated August 1, 2021, indicated all orders for medications and treatments must be dated and signed by the prescriber and must be current and consistent with the nursing assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39127	A. BUILDING: _____ B. WING _____	09/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOODHUE LIVING	108 COUNTY 9 BOULEVARD GOODHUE, MN 55027

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01970	Continued From page 20 days	01970		

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

Food & Beverage Inspection Report

Establishment Info

GOODHUE LIVING
108 COUNTY 9 BOULEVARD
Goodhue, MN 55027
Goodhue County
Parcel:

Phone:

License Info

License: HFID 39127

Risk:
License:
Expires on:
CFPM: Jennifer Loos
CFPM #: 43029; Exp: 1/22/2027

Inspection Info

Report Number: F8074261108
Inspection Type: Full - Single
Date: 9/21/2026 Time: 10:23:24 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 1
Total Priority 2 Orders: 0
Total Priority 3 Orders: 1
Delivery:

! **New Order: 5-200B Plumbing: cross connections**
5-203.14 *Priority Level: Priority 1 CFP#: 51*
MN Rule 4626.1085A Backflow prevention devices must be installed in accordance with chapter 4714.
COMMENT: Sidekick back flow preventer must be installed at mop sink where chemical dispenser is attached.
Comply By: 9/21/2026 Originally Issued On: 9/21/2026

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control
6-501.12A *Priority Level: Priority 3 CFP#: 55*
MN Rule 4626.1520A Clean and maintain all physical facilities clean.
COMMENT: Ceiling dusty by dish machine.
Comply By: 9/21/2026 Originally Issued On: 9/21/2026

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

I acknowledge receipt of the Rochester District Office inspection report number F8074261108 from 9/21/2026

Establishment Representative

Andrea Kieffer,
Public Health Sanitarian 3
507-206-2721
andrea.kieffer@state.mn.us

Rochester District Office
Minnesota Department of Health
3425 40th Avenue NW, Suite 115
Rochester, MN 55901

Temperature Observations/Recordings

Establishment Info

GOODHUE LIVING
Goodhue
County/Group: Goodhue County

Inspection Info

Report Number: F8074261108
Inspection Type: Full
Date: 9/21/2026
Time: 10:23:24 AM

Food Temperature: Product/Item/Unit: juice**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 38 Degrees F.
Comment: memory care area
Violation Issued?: No

Food Temperature: Product/Item/Unit: cucumber salad, melon**; Temperature Process:** Cold-Holding
Location: Walk-in Cooler at 36 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: milk**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 38 Degrees F.
Comment:
Violation Issued?: No

Rochester District Office
Minnesota Department of Health
3425 40th Avenue NW, Suite 115
Rochester, MN 55901

Sanitizer Observations/Recordings

Establishment Info

GOODHUE LIVING
Goodhue
County/Group: Goodhue County

Inspection Info

Report Number: F8074261108
Inspection Type: Full
Date: 9/21/2026
Time: 10:23:24 AM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Equal To 165 Degrees F.
Comment:
Violation Issued?: No

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: manifold **Equal To** 182 Degrees F.
Comment:
Violation Issued?: No

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL39127016	**Date:** 9/21/2026
Facility Name: Elysian Senior Homes LLC	
Facility Address: 108 County 9 Blvd., Goodhue, MN 55027	

☒ **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. Fire detection and alarm systems, emergency alarm systems, gas detection systems, fire-extinguishing systems, mechanical smoke exhaust systems and smoke and heat vents shall be maintained in an operative condition at all times and shall be replaced or repaired where defective. [Minn. Stat. 144G.45 subd. 2; MSFC 901.6]

   Comments: A smoke detector device was missing from fire alarm system hardware mounted on the ceiling of the second-floor storage closet. The base for a smoke detector head and the corresponding wiring was installed in the storage closet on the second-floor of the facility. The supplied fire alarm system hardware should be maintained with the corresponding devices present and in proper working condition. A detector head should be installed on the existing base mounting hardware and should be properly tied in with the fire alarm system and included devices.

3. Relocatable power taps (power strips) shall be directly connected to a permanently installed receptacle. 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 604.4.2, MSFC 604.4]

   Comments: Two multiplug adapter devices were connected in series and used to power electronics in resident room 3005. One of the supplied multiplug adapter devices failed to comply with NFPA requirements and was not approved for use in the facility. Power strips should be connected directly to wall outlet receptacles and should not be connected to other multiplug adapter devices. Unapproved multiplug adapters should be removed and their use discontinued to prevent risk of fire.

4. Exit signs shall be installed and maintained in accordance with the building code that was in effect at the time of construction and the applicable provisions in Section 1104. Decorations, furnishings, equipment or adjacent signage that impairs the visibility of exit signs, creates confusion or prevents identification of the exit shall not be allowed. [Minn. Stat. 144G.45 subd. 2; MSFC 1031.4]

   Comments: Signage reading "not an exit" was affixed to the exit door in the Southwest corner of the facility. This door was indicated as an emergency exit in the facility's fire safety and evacuation plan documents, on facility floor plans, and with lighted exit signage installed within the facility. The signage that indicated that this door is not an exit could have created confusion or prevented building occupants from correctly identifying the door as an exit and delayed exit in an emergency.

5. Controlled egress locking systems shall: unlock upon activation of either the automatic sprinkler system or automatic fire detection system, unlock upon loss of power controlling the lock, have the capability of being unlocked from the fire command center, a nursing station, or other approved location. Building occupants shall not be required to pass through more than one controlled egress locked door before entering an exit. The procedures for operation of the unlocking system shall be described as part of the fire safety and evacuation plan. All clinical staff shall have the keys, codes, or other means necessary to operate the locking device. Gates used as a component in a means of egress shall meet the same requirements for doors. [Minn. Stat. 144G.45 subd. 2; MSFC 1010.2, MSFC 1010.1.9.7]

   Comments:

   Exit signage was installed in the facility that indicated a path of egress travel going from the main lobby area near the kitchen through controlled egress doors into the memory care wing of the facility. The path of egress was indicated by lighted exit signs but was not included in floor plans or fire safety and evacuation plan documentation for the facility. This path of egress would require an occupant to pass through at least two controlled egress doors before reaching an exit. Occupants would be required to first pass through a controlled egress door to enter the memory care wing and would then be required to pass through either the North door in the dining area or the Southwest door leading to a stairwell which are both equipped with controlled egress hardware. A path of egress should not require passing through more than one controlled egress door before reaching an exit. Exit paths should be reviewed and approved to ensure they are appropriate.

   Exit signage was installed in the facility that indicated a path of egress from the memory care dining area out to a patio area. The patio area was secured with a fence spanning the perimeter of the area with two gates. The gate in the Northwest corner of the patio was secured shut with a padlock that required special knowledge and effort to open and was not readily accessible in an emergency. The gate on the East section of the patio fence appeared to have electromagnetic locking hardware. Facility staff indicated that they were unsure of how to operate this hardware and that they could not confirm the gate would unlock with the activation of the sprinkler system, loss of power, with automatic smoke

detection, or via the remote release hardware that operated the controlled egress doors within the memory care wing. The annual fire alarm panel report failed to indicate that the gate locking hardware was inspected or tied in with the facility's fire protection systems. Locking systems installed on the patio should comply with requirements for controlled egress or should be readily openable in the event of an emergency and maintained in proper working condition. Unapproved locking hardware poses a risk of delaying or preventing evacuation in an emergency. The locks installed on the patio gates were not approved and should comply with controlled egress requirements, be removed or be brought into compliance.

6. Egress doors shall be readily operable from the egress side without the use of a key or special knowledge. [Minn. Stat. 144G.45 subd. 2; MSFC 1010.1.9]

   Comments: Exit signage was installed in the facility that indicated a path of egress from the living room area through the salon. The path of egress was indicated by lighted exit signs but was not included in floor plans or fire safety and evacuation plan documentation for the facility. The doors on the salon were equipped with locking hardware that required special knowledge and a key to operate and which prevented ready evacuation through this route from the egress side of the doors. All locking devices installed on doors in the path of egress should be readily openable from the egress side of the doors.

☒ **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 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 provide site-specific staff actions for evacuation during a fire or similar emergency. The FSEP documents provided to the surveyor were general safety procedures and documents which failed to outline specific procedures for the evacuation of residents from the facility. The evacuation routes indicated in the FSEP documents varied between documents and were contradictory in some places. The FSEP should include site-specific staff actions for evacuation that are readily accessible in an emergency.