Electronically Delivered
October 19, 2026

Licensee
Good Shepherd Homes Inc
1211 4th Avenue North
Sauk Rapids, MN 56379

RE: Project Number(s) SL25644016

Dear Licensee:

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

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:

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 $500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,



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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25644	A. BUILDING: _____ B. WING _____	09/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD HOMES INC	1211 4TH AVENUE NORTH SAUK RAPIDS, MN 56379

(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: SL25644016-0 On September 8, 2026, through September 10, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 59 resident(s); 20 receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute 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, 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 10, 2026, for the specific Minnesota Food Code violations. The	0 480		

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0 480	Continued From page 3 Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure services were provided according to accepted health care, medical, or nursing standards in regard to infection control during resident cares and medication administration for one of three employees (unlicensed personnel (ULP)-E). This practice resulted in a level two violation (a violation that did not harm a client'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	0 510		

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0 510	Continued From page 4 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on September 8, 2026, at 9:59 a.m., agent/licensed practical nurse (A/LPN)-A stated the licensee provided medication management and assistance with ADLs (activities of daily living) to residents. On September 10, 2026, at 9:51 a.m., the surveyor observed ULP-E record R4's blood glucose level, complete hand hygiene and apply R4's Juxtalite (prescribed compression wraps) to R4's bilateral lower legs. ULP-E completed hand hygiene, applied gloves, washed and dried R4's abdominal folds and without changing gloves, ULP-E applied prescribed ointment to R4's abdominal folds. Without changing gloves or performing hand hygiene, ULP-E provided peri care to R4. Without changing gloves or performing hand hygiene, ULP-E applied prescribed ointment to R4's peri area skin folds. ULP-E then removed gloves, completed hand hygiene, and documented services provided. On September 10, 2026, at 10:24 a.m., ULP-E stated employees were trained to apply gloves before assisting residents with peri care and to wash hands after removing gloves and before entering another resident's apartment. ULP-E further stated ULP-E's gloves only touched the washcloth and towel used with R4; thus ULP-E didn't change ULP-E's gloves until the end of all cares. On September 10, 2026, at 3:09 p.m., A/LPN-A stated employees were trained to complete hand hygiene upon entering a resident's apartment,	0 510		

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0 510	Continued From page 5 when leaving a resident's apartment, and between glove changes. A/LPN-A further stated employees were trained to wear gloves with any direct care provided to residents, when the employee may need to touch a medication, and gloves should be changed anytime the employee moved from completion of a dirty task to a clean task. The licensee's Hand Hygiene policy dated August 2021, indicated hand hygiene was required when moving from a contaminated body site to a clean body site during resident care, after contact with environmental surfaces or equipment in the immediate vicinity of the resident, and after removing gloves or gowns. The licensee's Procedure for Using Gloves policy dated August 2021, indicated when gloves became soiled, the gloves were required to be removed, hand hygiene completed, and new gloves applied before beginning the next task. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
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	0 810		

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0 810	Continued From page 6 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 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	0 810		

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0 810	Continued From page 7 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 9, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	0 810		
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; (4) identification of persons responsible for monitoring medication supplies and ensuring that	01730		

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01730	Continued From page 8 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 registered nurse (RN) failed to develop and maintain a current individualized medication 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 client'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).	01730		

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01730	Continued From page 9 The findings include: During the entrance conference on September 8, 2026, at 9:59 a.m., agent/licensed practical nurse (A/LPN)-A stated the licensee provided medication management services to residents. R3 admitted to the licensee and began receiving assisted living services on October 14, 2024. R3 diagnoses included Chronic Obstructive Pulmonary Disease (lung disease causing restricted airflow and breathing difficulties), coronary artery disease (narrowing or blockage of the major blood vessels that supply the heart with oxygen-rich blood), depression, and hypertension (elevated blood pressure). R3's Service Plan (Waiver)- Addendum to Contract dated March 10, 2026, indicated R3 received medication administration three times daily and as needed. On September 9, 2026, at 8:06 a.m., the surveyor observed unlicensed personnel (ULP)-C administer scheduled medications and apply Juxtalite (compression garments) wraps to R3. While observing R3's care, the surveyor observed R3's open tube of pain relieving cream on R3's window ledge. R3's provider orders dated June 1, 2026, included an order for menthol/m-salicylate 10-15%- apply adequate amount to left shoulder and right knee two times daily as needed- ok to keep at bedside. R3's record included R3's Individualized Medication Management Plan dated July 22, 2026, indicated under the section titled 'Needs	01730		

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01730	Continued From page 10 med (medication) setup- needs medication set up by staff' the following: "Unlicensed staff to administer scheduled and PRN (as needed) medications per plan of care and facility policy." Under the section titled 'Interventions in place to prevent the diversion of medications by the resident or others who may have access to the medications, specify' the following was indicated: "Medications securely locked in medication cabinet in resident's apartment." Furthermore, the assessment indicated self-administration of medication was not applicable. R3's record lacked an individualized medication management plan to address the following: - documentation of specific resident instructions relating to the self-administration of medications. On September 9, 2026, at 8:14 a.m., R3 stated R3 utilized the pain cream when R3 desired. On September 10, 2026, at 2:51 p.m., A/LPN-A stated nursing was required to complete an assessment for safety and appropriateness with any resident who received medication management services and requested to self-administer a medication. R3's assessment was missed. The licensee's Individualized Medication, Treatment and Therapy Management Plans policy dated August 2021, indicated an RN developed a medication management plan for each resident receiving medication management services which included documentation of specific resident instructions related to the administration of medications. No further information was provided.	01730		

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01730	Continued From page 11 TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
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 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 the steps of the medication set-up process were followed for one of one employee, licensed practical nurse (LPN)-J. 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).	01760		

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	25644	A. BUILDING: _____ B. WING _____	09/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD HOMES INC	1211 4TH AVENUE NORTH SAUK RAPIDS, MN 56379

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01760	Continued From page 12 The findings include: During the entrance conference on September 8, 2026, at 10:06 a.m., agent/licensed practical nurse (A/LPN)-A stated the licensee provided medication management services to residents. LPN-J's employee record included evidence of LPN-J's nursing license which was issued on February 22, 2007, and expiration date was scheduled for April 30, 2027. R6's diagnoses included diabetes with diabetic nephropathy (nerve damage caused by long-term elevated blood glucose levels), arthritis (inflammation, stiffness, and pain in joints of the body), carotid artery disease (two major blood vessels in the neck become narrow or blocked due to buildup of fatty deposits), chronic kidney disease (kidney damage resulting in loss of ability to filter blood properly), hypertension (elevated blood pressure), depression, and congestive heart failure (chronic heart condition causing fluid retention). R6's Service Plan (Waiver)- Addendum to Contract dated October 14, 2025, indicated R6's services included medication setup every 14 days. R6's Provider Orders dated December 9, 2025, included orders for the following: - calcium (supplement) 600 milligrams (mg)/ vitamin D 800 international units (IU) - take one tablet daily; - multivitamin (supplement)- take one tablet daily; and - vitamin D3 (supplement) 1000 IU- take one tablet daily.	01760		

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01760	Continued From page 13 R6's Service Recap Summary- Month dated August 2026 indicated LPN-J completed medication setup for R6 on August 4, 2026, and August 18, 2026, respectively. R6's Service Recap Summary- Month dated September 2026 indicated LPN-J completed medication setup for R6 on September 1, 2026. On September 9, 2026, at 7:14 a.m., the surveyor observed unlicensed personnel (ULP)-C apply R6's Juxtalite (prescribed compression wraps) devices on R6's bilateral lower extremities. During this observation, the surveyor observed R6's medi-set next to a box with additional medication supplies. The following bottles of medication were observed to have expired: - calcium 600 mg/ 20 mcg, partial bottle, expired December 2025; - complete multivitamin adults, partial bottle, expired June 2026; - Century women's complete multivitamin/multimineral, partial bottle, expired June 2026; and - vitamin D3 1000 IU, partial bottle, expired January 2026. On September 9, 2026, at 7:24 a.m., R6 stated LPN-J completed R6's medication set-up every two weeks using the bottles observed on R6's counter. R6 further stated R6 did not have any additional medication supply which could have been used in R6's medication set-ups and LPN-J must have missed the expiration dates. On September 10, 2026, A/LPN-A stated nursing staff completed medication supply audits for expiration dates every 90 days. A/LPN-A further stated expiration dates should be checked during each medication set-up service for R6, and the	01760		

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01760	Continued From page 14 above medications were missed in error which resulted in medication errors. The licensee's Disposition of Medications policy dated August 2021, indicated disposal of unused medications which were stored in a resident's private living space were treated as household waste when destroyed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all 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 the medication refrigerator storing medications maintained an acceptable temperature and medications were stored according to manufacturer's recommended temperature. In addition, licensee failed to ensure over the counter (OTC) and prescription medications were stored in a securely locked and substantially constructed compartment permitting only authorized personnel to have access for one of one resident (R3). This practice resulted in a level two violation (a violation that did not harm a client's health or	01880		

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01880	Continued From page 15 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on September 8, 2026, at 9:59 a.m., agent/licensed practical nurse (A/LPN)-A stated the licensee provided medication management services to residents. MEDICATION REFRIGERATOR On September 9, 2026, at 8:15 a.m., the surveyor observed the licensee's refrigerator with unlicensed personnel (ULP)-C. ULP-C stated the current temperature was 34 degrees Fahrenheit (F). The current medication stored in the refrigerator was an unopened box of R3's Lantus (long-acting insulin) pens. The licensee's Miscellaneous Household Tasks Service history report dated August 9, 2026, through September 9, 2026, indicated the medications refrigerator temperature was expected to be read and documented daily and if the temperature was above 40 degrees F, instruction was to notify nursing staff. The Miscellaneous Household Tasks Service History included the following entries: - August 9, 2026, the temperature was 30 degrees F; - August 14, 2026, the temperature was 32 degrees F; - August 15, 2026, the temperature was 32 degrees F; - August 16, 2026, the temperature was 34	01880		

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01880	Continued From page 16 degrees F; - August 18, 2026, the temperature was 32 degrees F; - August 21, 2026, the temperature was 32 degrees F; - August 23, 2026, the temperature was 34 degrees F; - August 24, 2026, the temperature was 32 degrees F; - August 25, 2026, the temperature was 32 degrees F; - August 26, 2026, the temperature was 30 degrees F; - August 27, 2026, the temperature was 34 degrees F; - August 31, 2026, the temperature was 32 degrees F; - September 2, 2026, the temperature was 32 degrees F; and - September 7, 2026, the temperature was 30 degrees F. The Miscellaneous Household Tasks Service History lacked refrigerator temperature entries on the following days: - August 10, 2026; - August 13, 2026; - August 17, 2026; - August 19, 2026; - August 22, 2026; - August 28, 2026; and - September 4, 2026. The manufacturer's instructions for Lantus dated June 2022, indicated to store unopened Lantus in the refrigerator at 36 degrees F to 46 degrees F. Do not allow Lantus to freeze. On September 9, 2026, at 8:15 a.m., ULP-C stated an employee monitored and recorded the refrigerator temperature for R3 daily on evening	01880		

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01880	Continued From page 17 shift. On September 10, 2026, at 2:49 p.m., A/LPN-A stated refrigerator temperatures were required to be documented daily when medications were being stored in them. A/LPN-A further stated A/LPN-A was not aware of the low-end parameter of 36 degrees F and A/LPN-A was unsure why multiple dates were missing a temperature recording. SECURE STORAGE R3 admitted to the licensee and began receiving assisted living services on October 14, 2024. R3 diagnoses included Chronic Obstructive Pulmonary Disease (lung disease causing restricted airflow and breathing difficulties), coronary artery disease (narrowing or blockage of the major blood vessels that supply the heart with oxygen-rich blood), depression, and hypertension (elevated blood pressure). R3's Service Plan (Waiver)- Addendum to Contract dated March 10, 2026, indicated R3 received medication administration three times daily and as needed. R3's Individualized Medication Management Plan dated July 22, 2026, indicated under the section titled 'Needs med (medication) setup- needs medication set up by staff' the following: "Unlicensed staff to administer scheduled and PRN (as needed) medications per plan of care and facility policy." Under the section titled 'Interventions in place to prevent the diversion of medications by the resident or others who may have access to the medications, specify' the following was indicated: "Medications securely locked in medication cabinet in resident's	01880		

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01880	Continued From page 18 apartment." On September 9, 2026, at 8:06 a.m., the surveyor observed ULP-C administer scheduled medication to R3. During the medication administration observation, the surveyor observed the following medication in plain sight on R3's window ledge: - acetaminophen 500 milligrams (mg), partial bottle remained. R3's Provider Orders dated June 1, 2026, included an order for acetaminophen 500mg take two tablets three times daily as needed, doses need to be at least six hours apart. R3's over the counter (OTC) medications were not stored appropriately according to R3's medication management assessment. On September 9, 2026, at 8:16 a.m., R3 stated R3 took one or two tablets when needed for a headache. On September 9, 2026, at 8:36 a.m., ULP-C stated when an employee observes medication(s) in a resident's room that has not been ordered or approved for self-storage, the employee is required to notify the nurse. ULP-C further stated ULP-C had notified the licensee's previous clinical nurse supervisor (CNS). On September 10, 2026, at 2:51 p.m., A/LPN-A stated residents who received medication management services required a provider's order for over the counter (OTC) medications and to have an assessment completed for medication storage and appropriateness for self-administration by the registered nurse (RN).	01880		

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01880	Continued From page 19 The licensee's Storage of Medications policy dated August 2021, indicated an RN identified in each resident's individualized medication management plan the need for secure storage of medication if needed. The policy further indicated the RN educated the resident regarding proper storage of medication based on manufacturer's recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=F	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 opened and expiration dates for one of one resident (R3), whose medications were stored by the licensee. In addition, the licensee failed to monitor for expired medications in two of five resident apartments (R4 and R6). 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 20 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: During the entrance conference on September 8, 2026, at 9:59 a.m., agent/licensed practical nurse (A/LPN)-A stated the licensee provided medication management services to residents at the facility. TIME SENSITIVE MEDICATIONS On September 9, 2026, at 8:09 a.m., the surveyor observed R3's medication supply with unlicensed personnel (ULP)-C and observed the following: - R3's olodaterol/tiotropium bromide (relaxes airway smooth muscles and widens the lungs airways) 2.5 micrograms/actuation (mcg/act) inhaler, partially used, was not labeled with the date opened or expiration date; and - R3's Ozempic (injectable medication that manages blood glucose levels) 2 milligrams (mg) injection pen, partially used, was not labeled with the date opened or expiration date. On September 9, 2026, at 8:36 a.m., ULP-C stated employees were trained to label time sensitive medications with the date they are opened for first use. On September 10, 2026, at 2:26 p.m., A/LPN-A stated employees were trained to place a date opened sticker on time sensitive medications and the above medications were missed. EXPIRED MEDICATIONS On September 9, 2026, at 7:14 a.m., the surveyor observed R6's medication supplies with ULP-C	01890		

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01890	Continued From page 21 and observed the following: - R6's calcium (supplement) 600 mg, partial bottle remained, which expired December 2025; - R6's complete multivitamin (supplement), partial bottle remained, which expired June 2026; - R6's Century women's complete multivitamin (supplement), partial bottle remained, which expired June 2026; and - R6's vitamin D3 (supplement) 1000 internation units (IU), partial bottle remained, which expired January 2026. On September 10, 2026, at 9:51 a.m., the surveyor observed ULP-E administer scheduled medication and treatment to R4 and observed the following: - R4's Ventolin HFA 90 mcg/act inhaler, expired January 2026. On September 10, 2026, at 3:00 p.m., A/LPN-A stated ULPs audited medication supplies for expiration dates when medication cycle deliveries were completed and nursing completed medication supply audits when nursing assessments were completed every 90 days. A/LPN-A further stated the expired medications were missed in error. The manufacturer instructions for olodaterol/tiotropium bromide dated June 2025, directed to discard three months after the first use. The manufacturer instructions for Ozempic 2 mg dated October 2022, directed to discard 56 days after opening. The licensee's Storage of Medications policy dated August 2021, indicated the RN educated the resident regarding proper storage of	01890		

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01890	Continued From page 22 medication based on manufacturer's recommendations. The licensee's Disposition of Medications policy dated August 2021, indicated disposal of unused prescription medications managed by the licensee which were stored in the residents' private living space would be treated as household waste. The policy did not address destruction of expired medication. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=E	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition.	01910		

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01910	Continued From page 23 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record all required content for disposition of medications for two of three residents (R1 and R10) upon discharge. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on September 8, 2026, at 9:59 a.m., agent/licensed practical nurse (A/LPN)-A stated the licensee provided medication management services to residents at the facility. R1 R1's Discharge Care plan dated August 7, 2026, indicated R1 was admitted to the facility on November 22, 2023, and discharged on August 7, 2026. R1's Medication Disposition- Resident dated August 5, 2026, through September 8, 2026, lacked a prescription number for R1's prescriber albuterol sulfate inhaler (treats wheezing and shortness of breath through rapid airway opening).	01910		

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01910	Continued From page 24 R10 R10's Resident Note- Nurse dated April 3, 2026, through September 9, 2026, included a progress note written by registered nurse (RN)-H which indicated R10 was admitted to the facility on November 24, 2024, for medication management, assistance with activities of daily living (ADLs), and mobility support. The note further indicated R10 discharged to the licensee's long-term care facility on April 3, 2026, for continued nursing care. R10's record lacked a medication disposition report. On September 9, 2026, at 4:22 p.m., A/LPN-A stated medication disposition records were required to include the name, dose, and quantity of medication disposed of, the prescription number of each medication, who completed the disposition record, location of disposition, and if medications were not destroyed, the name of the person who received the medications for transport. A/LPN-A further stated RN-H transported R10's medications to the receiving facility however a medication disposition record was not completed for an unknown reason. The licensee's Disposition of Medications policy dated August 2021, indicated, "Documentation of the destruction, listing the date, quantity, strength, name of drug, nature of person destroying the drugs and signature of witness to the destruction may be recorded in the resident's record." The policy did not address inclusion of prescription numbers on the disposition summary. No further information was provided.	01910		

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01910	Continued From page 25 TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care standards, medical or nursing standards with regards to safely storing oxygen for one of four residents (R5) This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on September 8, 2026, at 10:19 a.m., agent/licensed practical nurse (A/LPN)-A stated the licensee provided oxygen management to residents at the facility. R5 was admitted to the licensee and began	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25644	A. BUILDING: _____ B. WING _____	09/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD HOMES INC	1211 4TH AVENUE NORTH SAUK RAPIDS, MN 56379

(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
02310	Continued From page 26 receiving assisted living services on June 3, 2026. R5's diagnoses included chronic pain syndrome, bipolar affective disorder (mental health condition causing extreme shifts in mood, energy and activity levels and emotional highs and lows), chronic kidney disease (kidney damage resulting in loss of ability to filter blood properly), chronic respiratory failure (lungs are unable to move oxygen into the blood or remove carbon dioxide), depression, generalized anxiety disorder, heart failure (heart muscle is unable to pump blood and oxygen well enough to meet the body's needs), and diabetes (chronic condition where the body cannot effectively process food into energy). R5's Service Recap Overall- Month dated July 2026, indicated R5 received daily monitoring for Covid symptoms on July 1, 2026, through July 31, 2026. On September 8, 2026, at 3:47 p.m., the surveyor accompanied by ULP-G, observed oxygen storage within R5's room and observed one oxygen concentrator and 24 portable oxygen tanks, 11 of which were not in an appropriate storage rack and were standing upright on the floor. On September 10, 2026, at 3:05 p.m., A/LPN-A stated portable oxygen tanks were to be stored upright in a storage rack. A/LPN-A further stated staff were trained to monitor for appropriate storage of oxygen supplies however the staff may have missed R5's due to R5 being independent with oxygen management. The Minnesota Department of Health (MDH) Oxygen Cylinder Storage Requirements dated	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25644	A. BUILDING: _____ B. WING _____	09/10/2026

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GOOD SHEPHERD HOMES INC	1211 4TH AVENUE NORTH SAUK RAPIDS, MN 56379

(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
02310	Continued From page 27 April 16, 2020, based on the National Fire Protection Association, Standard 99 (NFPA 99), indicated a common hazard in a health care facility is storing and handling compressed oxygen in cylinders. When storing oxygen cylinders, they must be secured in racks or by chains to prevent them from falling over. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL25644016-0	**Date:** September 9, 2026
Facility Name: GOOD SHEPHERD HOMES INC	
Facility Address: 1211 4th Ave N, Sauk Rapids, MN 56379	

☒ **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 FSEP was in a separate part of the campus that was attached by a hallway. Staff noted that it was locked inside staff office, not making it readily accessible in the event of an emergency.

2. 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 did not properly develop or maintain the facility's FSEP. The plan included instructions for staff to evacuate the building, but the plan failed to include procedures for how staff are to evacuate residents. Multiple policies were provided for review, and the FSEP included information from other facilities under the company's ownership rather than being specific to the facility surveyed. While the portions of the FSEP pertaining to the surveyed facility were compliant, the inclusion of multiple facility policies created unnecessary complexity and the potential for confusion.

3. 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: The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency.