Electronically Delivered

June 11, 2026

Licensee
Noah Assisting Living Inc.
5100 Xerxes Avenue North
Minneapolis, MN 55430

RE: Project Number(s) SL35867016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 7, 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 . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

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

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. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35867	A. BUILDING: _____ B. WING _____	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOAH ASSISTING LIVING INC	5100 XERXES AVENUE NORTH MINNEAPOLIS, MN 55430

(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: SL35867016-0 On May 4, 2026, through May 7, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were three (3) residents; 3 receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (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; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480		

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0 480	Continued From page 2 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 May 4, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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0 480	Continued From page 3 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 630 SS=E	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop an individual abuse prevention plan (IAPP) with the required content for two of three residents (R2, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of resident's are affected, more than a limited number of staff are involved or the situation has occurred repeatedly, but is not found to be pervasive). The findings include:	0 630		

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0 630	Continued From page 4 R2 R2 was admitted on November 4, 2025, and began receiving assisted living services. R2's Service Plan - Waiver signed on November 12, 2025, lacked identification of services R2 was receiving. R2's service log dated March 2026, indicated R2's services included assistance with behavior management, grooming, housekeeping, and safety checks. R2's IAPP completed on May 1, 2026, lacked documentation of R2's risk of abusing other vulnerable adults. R5 R5 was admitted on March 14, 2026, and began receiving assisted living services. R5's unsigned Service Plan dated May 5, 2026, indicated R5's services included assistance with dressing and grooming, behavior management, monitoring of vital signs, and safety checks. R5's IAPP completed on March 25, 2026, lacked documentation of R2's risk of abusing other vulnerable adults. On May 5, 2026, at 1:03 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated they were unaware of content missing from abuse prevention plans for R2 and R5. LALD/RN stated they would update their electronic documentation system to include the missing content. The licensee's Vulnerable Adult policy dated August 1, 2021, indicated an abuse prevention	0 630		

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0 630	Continued From page 5 plan would be established for each vulnerable adult receiving services and would include the resident's risk of abusing other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced	0 680		

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0 680	Continued From page 6 by: Based on interview and record review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents receiving services under the assisted living license. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On May 5, 2026, at 2:39 p.m., the surveyor was provided with a binder labeled Emergency Preparedness Plan. Manager (M)-B stated it was the emergency preparedness plan for the facility. The licensee's Emergency Preparedness Plan, undated, lacked the following required content: -documentation of participation in an annual full-scale exercise that was community based OR an annual, individual, facility-based functional exercise OR documentation if the facility experiences an actual emergency requiring activation of plan; -documentation of an additional annual exercise that may include: a second full-scale exercise that was community-based or an individual, facility based functional exercise OR mock disaster drill OR table-top exercise; and -analysis of the facility's response to and documentation of all drills, tabletop exercises and	0 680		

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0 680	Continued From page 7 emergency events & revisions to EPP. On May 5, 2026, at 2:45 p.m., M-B stated they thought that online training was inclusive of all employee training for emergency preparedness. M-B stated they had not conducted two disaster drills annually, but they would start conducting emergency preparedness drills. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated a disaster drill would be conducted at the residence at least annually and the results of the drill would be documented. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property for three of three residents (R2, R3, R5).	0 970		

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0 970	Continued From page 8 This practice resulted in a level one violation (a violation that that will cause only minimal impact on the residents and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R2's record included a [licensee name] Assisted Living Contract signed on November 3, 2025. R3's record included a [licensee name] Assisted Living Contract signed on September 18, 2024. R5's record included a [licensee name] Assisted Living Contract signed on March 13, 2026. R2, R3 and R5's contracts included the following clauses: -Miscellaneous Provisions (page 12): "1. The resident agrees that [name of licensee] will not be liable to the resident for any personal injury or property damage (including, without limitation, damage to, theft of, automobiles or personal property of resident) suffered by the resident ...unless and caused by the negligence of [name of licensee] or its employees or agents. The resident hereby releases [name of licensee] from liability for any personal injury or property damage suffered by the resident ...unless caused by the negligence of [name of licensee] or its employees or agents"; and -Miscellaneous Provisions (page 13): 6. "[Name of licensee] is not liable for any lost or stolen property, but in the event that happens we will investigate and document it as an incident and	0 970		

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0 970	Continued From page 9 report it to the relevant agencies". On May 5, 2026, at 2:00 p.m., the surveyor and manager (M)-B reviewed a blank contract for the licensee. M-B stated they used the same contract for all residents, and they had not changed the contract liability language since it was cited at their last survey. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01650 SS=E	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency;	01650		

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01650	Continued From page 10 and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included the required content for two of three residents (R2, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of resident's 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: R2 R2 was admitted on November 4, 2025, and began receiving assisted living services. R2's Service Plan - Waiver signed on November 12, 2025, lacked the following required content: -a description of the services to be provided, and the frequency of each service according to the residents' current assessment and preferences; -the identification of staff or categories of staff who will provide the services; and -the names and contact information of people the resident wishes to have notified in an emergency	01650		

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01650	Continued From page 11 or if there is a significant change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency. R5 R5 was admitted on March 14, 2026, and began receiving assisted living services. R5's Service Plan - Waiver signed on March 14, 2026, lacked the following required content: -description of the services to be provided, the fees for services, and the frequency of each service according to the resident's current assessment and preferences; -the identification of staff or categories of staff who will provide the services; and -the names and contact information of people the resident wishes to have notified in an emergency or if there is a significant change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency. On May 4, 2026, at 2:00 p.m., manager (M)-B stated they did not understand why the services were not shown on the service plans for R2 and R5. M-B stated they would contact their electronic documentation company to assist with resolving the issue. The licensee's Service Plan policy dated August 1, 2021, indicated the service plan would include the following content: -the fees for services and the frequency of each service, according to the residents' current review or assessment and resident preferences; -the identification of staff or categories of staff who will provide the services; and -names and contact information of people the	01650		

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01650	Continued From page 12 resident wishes to be notified in an emergency or if there is a significant adverse change in the resident's condition. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
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 interview and record review, the licensee failed to document medication administration in resident records for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35867	A. BUILDING: _____ B. WING _____	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOAH ASSISTING LIVING INC	5100 XERXES AVENUE NORTH MINNEAPOLIS, MN 55430

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01760	Continued From page 13 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted on November 4, 2025, and began receiving assisted living services. R2's record included a Service Plan Waiver signed November 12, 2025, lacking a description of services R2 was receiving. R2's Medication Administration Summary forms dated December 2025, January 2026, and February 2026 indicated the licensee failed to document the following medication administration for each of those months: Invega Sustenna injection (for schizophrenia), inject 117 milligrams (mg) intramuscularly every month. R2's record lacked documentation when medication administration was not completed as prescribed and any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed. On May 4, 2026, at 1:23 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated the licensee provided medication management and administration services from November 4, 2025, until March 19, 2026. LALD/RN-A stated R2 refused his monthly injection on December 20, 2025, January 20, 2026, and February 20, 2026. The licensee's Medication Documentation policy dated August 1, 2021, indicated if administration of medications was not completed, staff would	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35867	A. BUILDING: _____ B. WING _____	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOAH ASSISTING LIVING INC	5100 XERXES AVENUE NORTH MINNEAPOLIS, MN 55430

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01760	Continued From page 14 document the following: -the reason why the medication was not administered; -follow up procedures to meet the residents' needs in compliance with the medication management plan; -appropriate notification to RN supervisor or other persons as instructed regarding missed dosages; and -completion of a medication error report, if appropriate. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure there was a current, written, or electronically recorded prescription for prescribed medications that the assisted living facility was managing for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35867	A. BUILDING: _____ B. WING _____	05/07/2026

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01820	Continued From page 15 limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted on November 4, 2025, and began receiving assisted living services. R2's record included a Service Plan Waiver signed November 12, 2025, lacking a description of services R2 was receiving. R2's Medication Administration Summary dated November 2025, indicated R2 received Invega Sustenna 117 milligram (mg) injection (for schizophrenia) on November 20, 2025. R2's record lacked a signed physician's order for Invega Sustenna 117 mg injection. R2's record included an After Visit Summary (AVS) dated March 24, 2026, indicating the following instructions: -stop taking Invega Sustenna 117 mg monthly; and -start taking Latuda 40 mg tablet (for schizophrenia), take one half (1/2) tablet daily with evening meal. The AVS lacked a written or electronic signature from the prescribing provider. On May 5, 2026, at 2:00 p.m., manager (M)-B stated they could not locate the original provider order for Invega Sustenna for R2. On May 5, 2026, at 2:00 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated they obtain provider orders from the AVS and did not know they required an electronic or	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01820	Continued From page 16 written signature. The licensee's Prescriber's Orders policy dated August 1, 2021, indicated written orders from an authorized prescriber would be obtained for all medications and treatments with which the assisted living facility assists residents, including over the counter medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		

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

Food & Beverage Inspection Report

Establishment Info

Noah Assisting Living Inc
5100 Xerxes Ave N
Minneapolis, MN 55430
Parcel:

Phone:

License Info

License: HFID 35867

Risk:
License:
Expires on:
CFPM: Yaasin Cabdiraxmaan Jaamac
CFPM #: 43674; Exp: 6/10/2029

Inspection Info

Report Number: F8041261065
Inspection Type: Full - Joint
Date: 5/4/2026 Time: 11:00 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 2
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

! New Order: 3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) *Priority Level: Priority 1 CFP#: 15*

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

COMMENT: ISSUED 6/4/24 (REPEAT): UNPASTEURIZED SHELL EGGS STORED ABOVE READY TO EAT FOODS IN THE REFRIGERATOR. CORRECTED ON SITE. SHELL EGGS WERE MOVED TO THE BOTTOM SHELF IN THE REFRIGERATOR TO PREVENT CROSS CONTAMINATION.

Comply By: 5/4/2026 Originally Issued On: 5/4/2026

! New Order: 4-700 Sanitizing Equipment and Utensils

4-703.11B *Priority Level: Priority 1 CFP#: 16*

MN Rule 4626.0905B Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.

COMMENT: DISH MACHINE IS NOT WORKING. PER STAFF, NEW MACHINE SCHEDULED TO BE INSTALLED THIS AFTERNOON. SUBMIT PICTURE OF NEW MACHINE AND TEST STRIP ONCE IT IS INSTALLED TO VERIFY THE UTENSIL SURFACE TEMPERATURE IS AT LEAST 160F FOR SANITIZING. DISCUSSED HOW TO SET UP CONTAINERS TO WASH, RINSE AND SANITIZE DISHES AND UTENSILS UNTIL NEW MACHINE IS INSTALLED.

Comply By: 5/4/2026 Originally Issued On: 5/4/2026

Food & Beverage General Comment

Inspection was completed with Joyce Figueroa (MDH) and Zahra Juma. Michelle Winters was the HRD nurse evaluator.

Facility has a residential kitchen. Food must be prepared for same day service only. Kitchen has a smooth ceiling, vinyl floor tiles, wood cabinets with a hollow base with a solid surface countertop.

There is a two basin sink in the kitchen with one basin designated for handwashing. There is also a cabinet in the basement for dry food storage.

Discussed the following:
- Employee illness policy and logging requirements
- Reporting foodborne illness complaints to the health dept.
- Handwashing
- Date marking

-Glove-use and bare hand contact
- Proper food storage
-Vomit clean-up procedures
- Restrictions concerning serving a highly susceptible population

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

I acknowledge receipt of the Metro District Office inspection report number F8041261065 from 5/4/2026

Zahra Juma
Person in charge

Sarah Conboy,
Public Health Sanitarian Supervisor
651-201-3984
sarah.conboy@state.mn.us

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

Temperature Observations/Recordings

Establishment Info

Noah Assisting Living Inc
Minneapolis
County/Group:

Inspection Info

Report Number: F8041261065
Inspection Type: Full
Date: 5/4/2026
Time: 11:00 AM

Equipment Temperature: Product/Item/Unit: milk**; Temperature Process:** Cold-Holding
Location: Refrigerator at 37 Degrees F.
Comment:
Violation Issued?: No

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

Food & Beverage Inspection Report

Establishment Info

Noah Assisting Living Inc
5100 Xerxes Ave N
Minneapolis, MN 55430
Parcel:

Phone:

License Info

License: HFID 35867

Risk:
License:
Expires on:
CFPM:
CFPM #: ; Exp:

Inspection Info

Report Number: F8041261066
Inspection Type: Follow-up - Single
Date: 5/5/2026 Time: 2:12:02 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

A new dishwasher by GE has been installed. The utensil surface temperate is at least 170F for sanitizing. Pictures of newly installed machine and thermolabel emailed to inspector.

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

I acknowledge receipt of the Metro District Office inspection report number F8041261066 from 5/5/2026

Faisa

Sarah Conboy,
Public Health Sanitarian Supervisor
651-201-3984
sarah.conboy@state.mn.us

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

Temperature Observations/Recordings

Establishment Info

Noah Assisting Living Inc
Minneapolis
County/Group:

Inspection Info

Report Number: F8041261066
Inspection Type: Follow-up
Date: 5/5/2026
Time: 2:12:02 PM

Equipment Temperature: Product/Item/Unit: milk**; Temperature Process:** Cold-Holding
Location: Refrigerator at 37 Degrees F.
Comment:
Violation Issued?: No