Electronically Delivered

March 9, 2026

Licensee
Derman Senior Care Inc
2218 Doswell Avenue
Falcon Heights, MN 55108

RE: Project Number(s) SL34515016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 12, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

St - 0 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - $1,000.00
St - 0 - 0800 - 144g.45 Subd. 2 (a) (4) - Fire Protection And Physical Environment - $1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $2,000.00**. 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. 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,

Renee L. Anderson

Renee L. Anderson, Supervisor
State Evaluation Team
Email: Renee.L.Anderson@state.mn.us
Telephone: 651-201-5871 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
	34515	A. BUILDING: _____ B. WING _____	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERMAN SENIOR CARE INC	2218 DOSWELL AVENUE FALCON HEIGHTS, MN 55108

(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: SL #SL34515016-0 On February 9, 2026, through February 12, 2026, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were five residents, all of whom were receiving services under the provider's Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance 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 surveyors' 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 pursuant to 144G.31 Subd. 1, 2 and 3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of	0 470		

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0 470	Continued From page 1 staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to review their staffing plan two times annually to determine if staffing levels met the needs of all residents. 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	0 470		

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0 470	Continued From page 2 affect a large portion or all of the residents). The findings include: On February 9, 2026, at 11:30 a.m. during a facility tour, the surveyor observed the licensee's staffing plan located on the information board near the living room. The plan indicated staffing requirements for each shift were: one staff member for each of three shifts per day. The plan lacked evidence of being reviewed twice per year. On February 9, 2025, at 11:55 a.m. via phone, clinical nurse supervisor (CNS)-B stated she reviewed the staffing plan regularly, but she was "not sure where" she was supposed to document the review. The licensee's Staffing policy dated January 7, 2022, indicated the staffing plan would "be evaluated as part of the Quality Management program at least twice per year. The results of the evaluation are documented in the meeting minutes." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
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:	0 480		

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0 480	Continued From page 3 (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 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	0 480		

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0 480	Continued From page 4 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 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, Food and Beverage Establishment Inspection Report (FBEIR) dated February 9, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment	0 550		

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0 550	Continued From page 5 All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the required information related to the grievance procedure including information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). This had the potential to affect residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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).	0 550		

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0 550	Continued From page 6 The findings include: On February 9, 2025, at 11:35 a.m., the surveyor observed the licensee's information board in the main living room area with administrator (A)-C. The board contained a posting with the licensee's grievance procedure but lacked information for reporting suspected maltreatment to the MAARC. A-C stated a resident may have taken the posting down and he would get it replaced. The licensee's Vulnerable Adult policy dated January 7, 2022, indicated, "contact information for the MAARC shall be posted in the facility." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision.	0 660		

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0 660	Continued From page 7 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included baseline testing for one of three employees (clinical nurse supervisor (CNS)-B). 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: The licensee's facility TB risk assessment dated January 20, 2026, indicated the facility was a low risk for TB transmission. CNS-B was hired on December 4, 2024, and provided direct nursing care to the licensee's residents. On February 10, 2026, at 8:15 a.m., the surveyor observed CNS-B interacting with R4 in the kitchen area. CNS-B's employee record included a QuantiFERON TB Gold Plus test dated June 4, 2024, 183 days prior to hire date. CNS-B's record	0 660		

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0 660	Continued From page 8 lacked documentation of a TB blood test or TST completed within 90 days prior to hire date. On February 11, 2026, at 11:53 a.m., CNS-B stated she was not aware the QuantiFERON TB Gold Plus could not be greater than 90 days prior to hire date. The licensee's Tuberculosis Screening/Prevention policy dated January 7, 2022, indicated, "a second TST is not needed if the employee has a documented TST result within 90 days of date of hire. If a new employee has had a documented negative TST result within the previous 90 days, a single TST can be administered in the new setting before providing care." The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines indicated, Baseline TB screening consists of three components: 1. Assessing for current symptoms of active TB disease, 2. Assessing TB history, and 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single IGRA. Also included, an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record. In addition, HCW with a verbal (undocumented) history of a	0 660		

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0 660	Continued From page 9 previous positive TST or IGRA. These HCW's should undergo the same screening procedures as HCW's without previous positive results. Results of the screening should be documented in the HCW's record. If the HCW has documentation of previous treatment for latent TB infection or active TB disease, that documentation may be substituted for documentation of previous positive TST or IGRA results. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 775 SS=L	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 four violation (a violation harmed a resident ' s health or safety, not including serious injury or death, or a violation that was likely to lead to serious injury 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).	0 775		

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0 775	Continued From page 10 The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated February 10, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		
0 780 SS=I	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;	0 780		

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0 780	Continued From page 11 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 three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm? to the resident) and was 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated February 10, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a	0 790		

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	34515	A. BUILDING: _____ B. WING _____	02/12/2026

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0 790	Continued From page 12 minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced 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 February 10, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790		

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0 800	Continued From page 13	0 800		
0 800 SS=I	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm? to the resident) and was 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated February 10, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7)	0 800		

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0 800	Continued From page 14 days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (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 15 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 February 10, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	0 810		
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider	0 910		

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0 910	Continued From page 16 when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to execute a written assisted living contract with the required content for one of one resident (R2). This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2's record contained an "Assisted Living Contract" signed February 1, 2026. The contract contained the assisted living license number 420459, but lacked the health facility identification number (HFID). On February 10, 2026, at 9:15 a.m., the surveyor observed unlicensed personnel (ULP)-D prepare and administer medications to R2. On February 10, 2026, at 12:29 p.m., owner (O)-A identified R2's contract as the same contract used for all residents. On February 10, 2026, at 12:48 p.m., administrator (A)-E stated she was not aware the assisted living license and the HFID were not the	0 910		

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0 910	Continued From page 17 same number, and she would correct the mistake. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a Minnesota Department of Human Services (DHS) background study was submitted and received in affiliation with the assisted living license for one of six employees (administrator (A)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01290		

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01290	Continued From page 18 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: From February 10, 2026, to February 11, 2026, during the survey period, A-E provided the surveyor with resident and employee records. On February 10, 2026, at 11:22 a.m., administrator (A)-E stated she was hired in 2020 and provided administrative assistance at another site owned by the licensee. A-E stated she was only at the current location to "provide support" during the survey process. On February 10, 2026, at 12:48 p.m., A-E provided the surveyor with the licensee's Minnesota DHS NETStudy 2.0 background study roster. The NETStudy 2.0 roster lacked and indication A-E was affiliated with the licensee's health facility identification (HFID) 34515. A-E stated she did not realize she needed to be affiliated with the current location to provide assistance. On February 10, 2026, at 12:56 p.m., A-E provided the surveyor with the licensee's Minnesota DHS NETStudy 2.0 background study roster for HFID 36147. The roster indicated that A-E was affiliated with HFID 36147. The DHS NETStudy 2.0 User Manual updated July 7, 2023, indicated on page 16, the employee should be added to the roster where they will be	01290		

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01290	Continued From page 19 primarily affiliated. The manual further indicated on page 82, "entities must add study subjects to each of the rosters where the study subject is affiliated." The licensee's Recruitment and Hiring policy dated January 7, 2022, indicated " The Criminal Background Check will be submitted to Minnesota Department of Human Services (DHS) following the step-by-step procedure established by DHS. The policy lacked an indication that staff would be affiliated to each site. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor	01500		

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01500	Continued From page 20 blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01500		

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01500	Continued From page 21 review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of three employees (clinical nurse supervisor (CNS)-B). 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: CNS-B was hired on December 4, 2024, and provided direct nursing care to the licensee residents. On February 10, 2026, at 8:15 a.m., the surveyor observed CNS-B interacting with R4 in the kitchen area. CNS-B's employee record lacked documentation the employee had successfully completed at least eight hours of annual training for every 12 months of employment as required under 144G.63, Subd.5, to include the following: -training on reporting of maltreatment of vulnerable adults under section 626.557; -assisted living bill of rights; -infection control techniques; -effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; -review of providers policies and procedures; and	01500		

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01500	Continued From page 22 -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On February 11, 2026, at 11:53 a.m., CNS-B stated she had not completed the annual education. CNS-B stated she was not aware she needed to compete the education again and it was brought to her attention "a couple of weeks ago." The licensee's Staff Orientation and Education policy dated January 7, 2023, indicated all staff providing assisted living services would complete annual education that included all the required topics. The policy further indicated a record of the education would be kept in the employee file. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01530 SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness	01530		

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01530	Continued From page 23 and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure staff completed two hours of initial training on mental illness and de-escalation topics for three of three employees (clinical nurse supervisor (CNS)-B, unlicensed personnel (ULP)-D, ULP-G). 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	01530		

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01530	Continued From page 24 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: CNS-B, ULP-D and ULP-G were hired December 4, 2024, January 22, 2025, and November 28, 2023, respectively, to provide direct cares to the licensee's residents. The licensee's Weekly Staff Schedule dated for the weeks of February 2, 2026, and February 9, 2026, indicated ULP-D and ULP-G worked Monday through Friday 8:00 a.m. to 3:00 p.m., and 3:00 p.m. to 11:00 p.m., respectively. On February 10, 2026, at 8:15 a.m., the surveyor observed CNS-B interacting with R4 in the kitchen area. -at 9:15 a.m., the surveyor observed ULP-D assisting R2 with medication administration. R2's medication administration record (MAR) for February 2026, indicated ULP-G assisted R2 with medication administration February 2, 3, 4 and 5, 2026. CNS-B, ULP-D, and ULP-G's employee record lacked documentation two hours of initial training was completed on mental illness and de-escalation topics effective July 1, 2025. On February 11, 2026, via phone at 10:10 a.m., licensed assisted living director (LALD)-F stated he was aware of the requirement. LALD-F further stated the licensee was working on getting a	01530		

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01530	Continued From page 25 comprehensive education training on mental illness for their staff, but they were behind. The licensee's Dementia Education policy dated January 7, 2022, indicated all staff of licensee would complete dementia training in accordance with Minnesota Statutes, section 144G.64, and training would occur within the required timeframe based on staff roles and would continue annually. The policy lacked an indication employees would receive education on mental illness and de-escalation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01610 SS=F	144G.70 Subd. 2 (a-b) 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 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.	01610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34515	A. BUILDING: _____ B. WING _____	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERMAN SENIOR CARE INC	2218 DOSWELL AVENUE FALCON HEIGHTS, MN 55108

(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
01610	Continued From page 26 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed an initial comprehensive nursing assessment on, or before, the date of admission for one of two 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 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: R3 was admitted to the licensee on July 21, 2025. R3's Resident Profile dated February 10, 2026, indicated R3 received services including medication management. R3's Admission Assessment was completed on August 8, 2025, 18 days after R3's date of admission. On February 10, at 11:22 a.m., the surveyor observed R3 walking through the kitchen area, talking to ULP-D. On February 11, 2026, at 5:26 p.m., clinical nurse supervisor (CNS)-B stated R3's admission assessment was closed on August 8, 2025. CNS-B stated they thought they could continue to	01610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34515	A. BUILDING: _____ B. WING _____	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERMAN SENIOR CARE INC	2218 DOSWELL AVENUE FALCON HEIGHTS, MN 55108

(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
01610	Continued From page 27 add information to the assessment, so she had kept it open. The licensee's Assessment and Reassessment policy dated January 7, 2022, indicated the registered nurse (RN) would complete a comprehensive nursing assessment upon admission. The policy further indicated the RN would provide a reassessment visit to update the evaluation of the resident and services no more than 14 days after the initiation of services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01610		
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medication	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34515	A. BUILDING: _____ B. WING _____	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERMAN SENIOR CARE INC	2218 DOSWELL AVENUE FALCON HEIGHTS, MN 55108

(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
01760	Continued From page 28 administration was documented accurately in the electronic medication administration record (EMAR) for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 was admitted to licensee's assisted living facility on February 1, 2026. R2's Service Plan (Waiver)- Addendum to Contract effective February 1, 2026, indicated R2 received services which included assistance with medication administration. R2's provider orders dated January 30, 2026, included Ingrezza (used to treat involuntary, repetitive movements) 40 milligrams (mg) take one capsule once daily. R2's EMAR dated February 2026, indicated Ingreeza had been given at 10:00 p.m., beginning February 2, 2026. On February 3, 2026, at 11:02 a.m., the surveyor observed unlicensed personnel (ULP)-D prepare and administer R2's medications. ULP-D prepared two medications for morning administration, which included one Ingreeza 40 mg capsule. ULP-D was observed to remove the Ingreeza medication card from a locked cabinet,	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34515	A. BUILDING: _____ B. WING _____	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERMAN SENIOR CARE INC	2218 DOSWELL AVENUE FALCON HEIGHTS, MN 55108

(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
01760	Continued From page 29 punch one Ingreeza capsule out of the card, and place the capsule into the medication cup. ULP-D was observed to give the medication cup to R2, who swallowed the medication with water. ULP-D tried to locate the Ingreeza medication on the EMAR to document as given; however, Ingreeza was not listed on the EMAR for administration. On February 10, 2026, at 9:25 a.m., ULP-D stated they had given R2 Ingreeza previously on each of the day shifts they had worked; however, did not document the medication administration due to Ingreeza not being listed on the EMAR. ULP-D stated their process was to prepare and administer medications to the licensee's residents and then document them as given. ULP-D further stated there was no particular reason why they did not compare the residents' medications to MAR before giving the medications. On February 10, 2026, at 10:10 a.m., administrator (A)-E stated Ingreeza should have only been given at night, and ULP-D would have made a medication error. On February 11, 2026, at 11:53 a.m., clinical nurse supervisor (CNS)-B stated the ULP were trained on the five rights of medication administration (right patient, right drug, right dose, right route, and right time) and she was not sure why the process would not have been followed. The licensee's Medication Documentation policy dated January 7, 2022, indicated all medications administered by staff would be documented the resident's clinical record. The policy further indicated complete documentation of medication administration included the resident's name, medication name, medication dosage, date and time of administration, method/route of	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34515	A. BUILDING: _____ B. WING _____	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERMAN SENIOR CARE INC	2218 DOSWELL AVENUE FALCON HEIGHTS, MN 55108

(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
01760	Continued From page 30 administration and the signature and title of the staff who administered the medication. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		

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

Derman Senior Care LLC
2218 Doswell Ave
St Paul, MN 55108
Ramsey County
Parcel:

Phone:

License Info

License: HFID 34515

Risk:
License:
Expires on:
CFPM: Amal A. Jama
CFPM #: 120214; Exp: 12/07/2026

Inspection Info

Report Number: F1021261038
Inspection Type: Full - Single
Date: 2/9/2026 Time: 12:38:30 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 2
Total Priority 2 Orders: 3
Total Priority 3 Orders: 1
Delivery: Emailed

New Order: 4-300 Equipment Numbers and Capacities
4-302.13B *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.
COMMENT: ESTABLISHMENT HAS A DIGITAL LOLLIPOP THERMOMETER ON-SITE BUT THE DISH MACHINE CYCLE IS 2+ HOURS LONG. DISCUSSED WITH ADMINISTRATOR THAT THE DIGITAL THERMOMETER WILL TURN OFF AFTER A FEW MINUTES. PROVIDE THERMOLABELS FOR RESIDENTIAL DISH MACHINE. ONE THERMOLABEL LEFT ON-SITE.
Comply By: 2/16/2026 Originally Issued On: 2/9/2026

New Order: 4-300 Equipment Numbers and Capacities
4-302.14 *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.
COMMENT: NO TEST KIT ON-SITE TO MEASURE THE CONCENTRATION OF BLEACH. PROVIDE.
Comply By: 2/16/2026 Originally Issued On: 2/9/2026

! **New Order: 4-700 Sanitizing Equipment and Utensils**
4-702.11 *Priority Level: Priority 1 CFP#: 16*
MN Rule 4626.0900 Sanitize utensils and food contact surfaces of equipment before use, after cleaning.
COMMENT: CLEAN DISHES WERE OBSERVED IN THE DRYING RACK. PER CONVERSATION WITH STAFF, THE DISHES HAD ONLY BEEN WASHED AND RINSED. STAFF WERE REMINDED THAT ALL DISHES AND UTENSILS MUST BE WASHED, RINSED, AND SANITIZED. ENSURE THE DISHWASHER IS USED TO PROPERLY CLEAN ALL DISHES AND UTENSILS.
Comply By: 2/9/2026 Originally Issued On: 2/9/2026

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: DUST WAS OBSERVED ACCUMULATING ABOVE THE KITCHEN CABINETS AND ON THE CEILING. THE LIGHT FIXTURE FAN BLADES ALSO HAD GREASE AND DUST BUILDUP. CLEAN AND MAINTAIN CLEAN.
Comply By: 2/13/2026 Originally Issued On: 2/9/2026

New Order: 7-100 Toxic Labeling
7-102.11 *Priority Level: Priority 2 CFP#: 28*
MN Rule 4626.1595 Clearly label all working containers used for storing poisonous or toxic materials from bulk supplies such as sanitizers and cleaners, with the common name of the product.
COMMENT: THE LABELS ON THE SPRAY BOTTLES CONTAINING BLEACH WATER SANITIZER SOLUTION AND SOAP/WATER WERE SWAPPED. STAFF CORRECTED THE ERROR AND RELABELED THE SPRAY BOTTLES ACCURATELY. CORRECTED ON-SITE.
Comply By: 2/9/2026 Originally Issued On: 2/9/2026

! **New Order: 7-200 Toxic Supplies and Applications**
7-204.11 *Priority Level: Priority 1 CFP#: 28*
MN Rule 4626.1620 Discontinue using chemical sanitizers, including chemical sanitizing solutions generated on site and other chemical antimicrobials on food-contact surfaces that do not meet the requirements specified in 40 CFR part 180, section 180.940, or part 180, subpart E, section 180.2020.
COMMENT: BLEACH ON-SITE WAS FOUND TO BE A LAUNDRY/BATHROOM PRODUCT AND IS NOT APPROVED FOR USE ON FOOD CONTACT SURFACES. THE LABEL DOES NOT INDICATE IT IS SAFE FOR FOOD CONTACT. APPROVED SANITIZING SOLUTIONS WERE REVIEWED WITH STAFF. STAFF WILL OBTAIN AN APPROVED BLEACH FOR FOOD CONTACT SURFACES.
Comply By: 2/9/2026 Originally Issued On: 2/9/2026

Food & Beverage General Comment

All findings on this report were discussed with Administrator, Osman Aden and Health Regulation Division Nurse Evaluator, Tammy Carlson.

This facility is a residential home, and they currently have 5 clients and the facility can accommodate up to 5 clients.

Food is for same-day service. Leftovers are discarded at the end of service.

The kitchen has residential equipment, wood floors, laminate countertops, textured ceiling, wood cabinets and painted drywall. Physical facility items will be monitored during future inspections.

The establishment is using a residential dishwasher that is not permanently plumbed into the kitchen. Staff are currently moving and connecting the dishwasher to the two-compartment sink, using one of the faucets while the other is blocked during use. Per conversation with staff, they will use the dishwasher at night when the two compartment sink is not in use. This is a temporary fix. The dishwasher must be permanently plumbed and accessible for use.

A temperature indicator (thermolabel) was left on-site to verify that the residential dishwasher achieves a utensil surface temperature of 160°F or higher. Staff will email the inspector a photo of the thermolabel.

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 F1021261038 from 2/9/2026

Melissa Ramos

Osman Aden
Administrator

Melissa Ramos,
Public Health Sanitarian 3
651-201-4495
melissa.ramos@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

Derman Senior Care LLC
St Paul
County/Group: Ramsey County

Inspection Info

Report Number: F1021261038
Inspection Type: Full
Date: 2/9/2026
Time: 12:38:30 PM

Food Temperature: Product/Item/Unit: Milk**; Temperature Process:** Cold-Holding
Location: Maytag Kitchen Refrigerator at 40 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Shredded Cheese **; Temperature Process:** Cold-Holding
Location: Maytag Refrigerator at 41 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: Maytag Refrigerator **; Temperature Process:** Ambient Air
Location: Maytag Refrigerator at 39 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Hot Dogs **; Temperature Process:** Cold-Holding
Location: Second Refrigerator at 39 Degrees F.
Comment:
Violation Issued?: No

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

Sanitizer Observations/Recordings

Establishment Info

Derman Senior Care LLC
St Paul
County/Group: Ramsey County

Inspection Info

Report Number: F1021261038
Inspection Type: Full
Date: 2/9/2026
Time: 12:38:30 PM

Sanitizing Chemical: **Product:** Chlorine**; Sanitizing Process:** Spray Bottle
Location: Kitchen **Equal To** 100 PPM
Comment:
Violation Issued?: No

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL34515016	**Date:** 2/10/2026
Facility Name: Derman Senior Care	
Facility Address: 2218 Doswell Ave., St. Paul, MN 55108	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 4; 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. Required egress window openings in rooms of care facilities licensed or registered by the state of Minnesota shall have a minimum net clear opening area of 4.5 square feet (648 square inches). Opening height and width dimensions shall not be less than 20 inches. The net clear opening dimensions shall be the result of normal operation of the opening. [Minn. Stat. 144G.45 subd. 2; MSFC 1104.26.2, 1104.26.6.1]

   Comments:

   A storage closet labeled as room 6 was set up as a sleeping room and was in use for sleeping by a resident during the survey. Room 6, where the resident had reportedly been utilizing it for sleeping for several days, had only one window. That window had an openable area measuring 13.5 inches high and 22.5 inches wide. The egress window in this resident room was not compliant, and the room was approved as a sleeping room by [whoever said the resident could sleep in there, or the egress maps, etc.]. During the survey, the bed and other sleeping items were removed from room 6 and relocated back into a room with properly sized egress windows. All resident rooms must have compliant means of egress and appropriately sized windows.

   The egress window in resident room 5 was covered in plywood that was screwed into the window frame and taped over, preventing the window from being readily accessed in an emergency. The minimum openable area must remain unobstructed, and egress windows must be accessible.

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

Comments: A significant number of cigarette butts were located on the wooden ramp walkway along the side and rear of the facility, in the front yard, in the side yard, and on the rear patio landing. Cigarette butts were observed laying on the wooden walkway, on the dried lawn vegetation and on a plastic trash can on the walkway. The were numerous scorch and burn marks on the carpeting of the rear porch area showing significant risk of fire hazard. Smoking materials were not properly disposed. All smoking materials should be properly disposed of in approved receptacles to minimize risk of fire hazard.

4. Portable, electric space heaters shall not be plugged into extension cords. [Minn. Stat. 144G.45 subd. 2; MSFC 604.10.3]

   Comments: *An unapproved space heater was in use in the front dining room area of the facility and was connected via an extension cord. The outlet that the space heater was plugged into showed burn marks that indicated that there had been a short that could have started a fire.*

5. Where used in Group I-2 (ALFDC) and ambulatory care facilities, portable, electric space heaters shall be limited to those having a heating element that cannot exceed a temperature of 212°F (100°C), and such heaters shall only be used in nonsleeping staff and employee areas. [Minn. Stat. 144G.45 subd. 2; MSFC 604.10.5]

   Comments: An unapproved space heater was in use in resident room 6 which posed a risk of fire hazard.

6. Extension cords and flexible cords shall not be a substitute for permanent wiring and shall be listed and labeled in accordance with UL 817. Extension cords and flexible cords shall not be affixed to structures, extended through walls, ceilings or floors, or under doors or floor coverings, nor shall such cords be subject to environmental damage or physical impact. Extension cords shall be used only with portable appliances. Extension cords marked for indoor use shall not be used outdoors. [Minn. Stat. 144G.45 subd. 2; MSFC 604.5] Relocatable power taps (power strips) shall be directly connected to a permanently installed receptacle. [Minn. Stat. 144G.45 subd. 2; MSFC 604.4.2]

   Comments:

   Multiple extension cords were in use and were connected together, being used in lieu of permanent wiring in the upper-level office area. These extension cords were utilized to power multiple office appliances. Extension cords should not be utilized in lieu of permanent wiring.

   Multiple extension cords were in use and were connected together, being used in lieu of permanent wiring in resident room 5. These extension cords were utilized to power personal electronics and appliances. Extension cords should not be utilized in lieu of permanent wiring.

7. Relocatable power taps (power strips) shall be directly connected to a permanently installed receptacle. [Minn. Stat. 144G.45 subd. 2; MSFC 604.4.2]

   Comments: An unapproved multiplug adapter was in use in the basement laundry room to power multiple devices, including the washer and dryer. Unapproved multiplug adapters should be removed, and appliances should be connected directly to a permanently installed receptacle.

8. Clothes dryers and their exhaust systems shall be cleaned as necessary to keep lint traps, exhaust ducts, and mechanical and heating components free from excessive lint accumulation. [Minn. Stat. 144G.45 subd. 2; MSFC 304.4]

   Comments: There was a significant accumulation of lint behind the dryer, which posed a fire hazard. A significant amount of lint had spewed out into the space behind the dryer and built up in that space. Lint also had accumulated within the dryer vent, and the vent opening was covered in lint. The accumulated lint behind the dryer should be removed and maintained free of lint as it may pose a fire hazard.

9. The means of egress shall be maintained free of obstructions or impediments to full instant use in case of fire or other emergency. [Minn. Stat. 144G.45 subd. 2; MSFC 1031.2]

   Comments: Snow and ice were not cleared from the egress path from the rear yard to the public right of way. The accumulated snow and ice obstructed the path from ready egress. The snow and ice should be removed and the path of egress maintained free of obstruction.

☒ **TAG IDENTIFICATION: 0780**

SCOPE/ SEVERITY: Level 3; Pattern **TIME PERIOD OF CORRECTION:** Seven (7) days

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1. Smoke alarms are provided in each room used for sleeping purposes. [Minn. Stat. 144G.45 subd.2]

   Comments: Resident room 2 did not have a smoke alarm installed. All rooms used for sleeping must have a functional smoke alarm equipped and maintained.

2. Smoke alarms are provided on each story, including basements, but not including unoccupied attics or crawlspaces. [Minn. Stat. 144G.45 subd.2]

Comments: No smoke alarm was present in the basement level. An old smoke alarm mount was present without a smoke alarm installed near the laundry and water heater in the basement. A smoke alarm must be provided and maintained operable on each level.

3. Smoke alarms interconnected so that actuation of one alarm causes all alarms in the individual dwelling or sleeping unit to operate where more than one smoke alarm is required within an individual dwelling or sleeping unit. [Minn. Stat. 144G.45 subd.2]

   Comments: Smoke alarms are not properly interconnected throughout the facility. When the licensee tested the alarms, the smoke alarms in resident room 3 and room 7 were not interconnected with the other provided alarms. Smoke alarms must be interconnected such that the activation of any one alarm causes all other alarms to sound.

☒ **TAG IDENTIFICATION: 0790**

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

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

   Comments: Signage indicating a fire extinguisher was present in the upper-level office labeled as room 7 within the facility. No extinguisher was readily locatable in the office near the signage. The extinguisher was located tucked in the back of a closet and was only accessible by moving items out of the way. It took considerable time to access the extinguisher, and it was not properly mounted. All extinguishers provided should be properly mounted and accessible.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 3; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

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

Comments:

The elevated wooden walkway landing near the side door on the upper-level had a rotten floorboard which was not secure and sagged inward when walked on. The rotten board may pose tripping or falling hazard and should be replaced and maintained in good condition.

Several sections of the railing along the elevated wooden walkway were damaged. There were sections with missing or loose balusters, cracked balusters, screws pulling loose, and damaged boards. The railings along the walkway prevent falls and should be maintained in proper condition.

The wooden patio area on top of the garage had broken railing and loose floorboards. Staff stated that the area is not utilized due to not being in an acceptable condition.

The outlet in the dining room area near the front entry was damaged and showed evidence of burn marks where the outlet had an electrical short. The top portion of the outlet was not functional. The outlet should be replaced and maintained free of damage.

There were holes in the walls in resident room 5. The drywall had been damaged and pushed in in several locations. The holes and damage should be repaired, and the walls should be maintained in proper condition.

The door frame in resident room 2 was damaged with a hole present along the top of the door assembly.

The upper-level bathroom did not have proper piping beneath the sink. A flexible pipe was provided which does not meet requirements. The flexible piping should be removed and approved rigid smooth plumbing should be installed and maintained.

The lower-level bathroom did not have proper piping beneath the sink. A flexible pipe was provided which does not meet requirements. The flexible piping should be removed and approved rigid smooth plumbing should be installed and maintained.

The bathroom ventilation vent was significantly dirty and covered with dust in the upper-level bathroom. The vent should be cleaned to prevent the accumulated dust from impacting the fan motor and to maintain clean and sanitary surfaces.

The electrical outlet in resident room 4 was not securely connected to the wall. The outlet was hanging loose and should be resecured and maintained in proper working order.

The lighting fixture in room 6 was missing a protective globe. A protective globe should be supplied and maintained around the light fixture.

The outlet cover in the upper-level office labeled room 7 was damaged and broken. The outlet cover should be replaced and maintained to properly cover the electrical fixture.

The windows in the living room on either side of the television area were damaged and would not fully close if opened.

The window screen on the window to the north of the television area in the living room was bent and damaged.

The electrical outlet in the living room was damaged and pulled loose from the wall. The outlet should be resecured and maintained in proper condition.

The lower-level bathroom showed evidence of moisture damage with chipping paint and decaying wood around the bathroom mirror trim, and pieces of the bathroom window frame were damaged and missing. The bathroom should be maintained in good condition.

The electrical outlet in resident room 1 was damaged and pulled loose from the wall. The outlet should be resecured and maintained in proper condition.

The closet doors had become disconnected from the tracks in the closet opening in resident room 1. The doors should be repaired and secured to prevent them from falling on someone utilizing the closet.

The dryer ventilation was not properly connected to the clothes dryer. Ventilation should be securely attached and maintained to properly vent lint away from the dryer.

The tiles in the living room were peeling up. Flooring should be maintained in a flush, safe condition to prevent tripping hazards.

☒ **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 FSEP did not include any specific procedures for evacuation that were relevant to the facility. The provided documentation included general fire safety tips, but the information was not site-specific or relevant to the facility and did not constitute a proper procedure for evacuation.

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

   Comments: The FSEP did not include any specific procedures for evacuation for residents. The only information provided was general safety tips, but no specific procedures for evacuating were provided.

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

   Comments: FSEP documentation provided priority levels for residents but did not include all current residents, nor did it outline specific needs for each resident relevant to evacuation or relocation. The identification of unique resident needs should be specific and should be updated regularly to ensure it is accurate.

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

   Comments: No documentation of staff training was located in the FSEP or provided during the survey.

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

   Comments: No documentation of resident training was located in the FSEP or provided during the survey.