Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

November 6, 2025

Licensee
Imran Healthcare Services LLC
5543 Penn Avenue South
Minneapolis, MN 55419

RE: Project Number(s) SL39270015

Dear Licensee:

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

The Minnesota Department of Health completed an initial survey on October 2, 2025, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

St - 0 - 0110 - 144g.10 Subdivision 1a - Assisted Living Director License Required - $500.00

The total amount you are assessed is $500.00. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this

section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by MDH within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

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

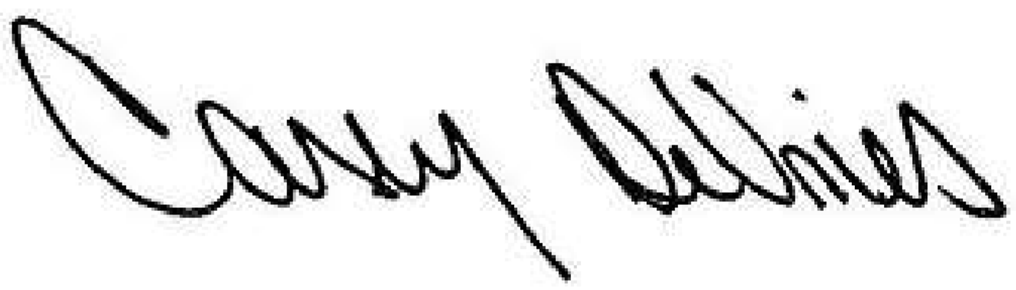
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration or a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms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

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



Casey DeVries, Supervisor
State Evaluation Team
Email: Casey.DeVries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

KKM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39270	A. BUILDING: _____ B. WING _____	10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IMRAN HEALTHCARE SERVICES LLC	5543 PENN AVENUE SOUTH MINNEAPOLIS, MN 55419

(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: SL39270015-0 On September 29, 2025, through October 2, 2025, 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 no residents; none receiving services under the Provisional 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 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 issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required	0 110		

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director who is licensed or permitted by the Board of Executives for Long Term Services and Supports and affiliated as the director of record with the board. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the director of record for the licensee with the Board of Executives for Long-Term Services and Support (BELTSS). This had the potential to affect all of the licensee's residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 29, 2025, at 3:15 p.m., via telephone, unlicensed personnel/owner (ULP/O)-D stated their LALD in residence permit was expired and they were planning to do the required exam, but they were unable to take it due to personal problems. ULP/O-D stated clinical nurse supervisor (CNS)-C was the current LALD. The surveyor asked ULP/O-D why CNS-C was not listed as director of record on BELTSS.	0 110		

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0 110	Continued From page 2 ULP/O-D stated, "Is that what it is?" ULP/O-D stated CNS-C told them that they would support them, but they must hire another LALD. ULP/O-D further stated their plan was to hire someone else as LALD. On September 29, 2025, at approximately 8:00 a.m., the surveyor observed the Board of Executives for Long-Term Services and Support (BELTSS) website which indicated ULP/O-D held assisted living director residency permit license effective August 1, 2024, and expired on July 31, 2025. The surveyor also observed CNS-C held a LALD license valid through October 31, 2026, but was not affiliated to the licensee's health facility identification number (HFID)# 39270. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to	0 460		

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0 460	Continued From page 3 enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 30, 2025, at approximately 9:00 a.m., during the entrance conference, unlicensed personnel/owner (ULP/O)-D stated there was no system in place for their resident to seek staff's assistance. ULP/O-D stated the resident they formerly had was independent and did not need help. R1 was admitted to the licensee on June 9, 2025, with diagnoses including post-traumatic stress disorder, pelvic and perineal pain, and discharged from the licensee on July 14, 2025. R1's Service Plan signed and dated June 12,	0 460		

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0 460	Continued From page 4 2025, indicated R1 received services for bathing assistance, dressing, grooming, medication administration, meal assistance, and mange behavior. On September 30, 2025, at 9:20 a.m., during a facility tour, the surveyor observed a split-level side by side duplex home with no bells, call lights, pendants, or other means for the resident to seek staff's assistance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 460		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570;	0 480		

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0 480	Continued From page 5 (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (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.	0 480		

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0 480	Continued From page 6 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated September 30, 2025, 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 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	0 550		

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0 550	Continued From page 7 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 and reporting contact information for the Office of Health Facility Complaints (OHFC). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 30, 2025, at 9:25 a.m., during the facility tour, the surveyor observed contact information for the Office of Ombudsman for Long Term Care (OOLTC), Office of Ombudsman for Mental Health and Developmental Disabilities (OMHDD), and Minnesota Adult Abuse Reporting Center (MAARC), posted on a bulletin board in the living room, on both sides of the licensee's duplex facility. The surveyor observed the licensee lacked the following postings on both sides of the licensee's duplex facility: - OHFC contact information. On September 30, 2025, at 9:25 a.m., unlicensed personal/owner (ULP/O)-D stated they were not	0 550		

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0 550	Continued From page 8 aware of the requirement to post the above listed contact information. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 660 SS=D	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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to 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 a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test, completed upon hire or 90 days prior to hire for one of three employees (registered nurse	0 660		

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0 660	Continued From page 9 (RN)-E). This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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: RN-E was hired on June 8, 2025, to provide oversight to the licensee's employees and to provide direct care services to residents. RN-E's employee record included a negative QuantiFERON- TB gold plus result dated February 8, 2024, 486 days prior to RN-E's hire date. RN-E's employee record also included a blank Base Line TB Screening Tool for Health Care Personnel. RN-E's employee record lacked evidence of TB screening such as a TB skin test or blood test and that baseline TB screening was completed upon hire or 90 days prior to hire. On October 2, 2025, at 12:52 p.m., unlicensed personnel/owner (ULP)/O-D stated they were not aware of the requirement for TB screening to be completed upon hire or 90 days prior to hire. ULP/O-D stated, "Do we have to do that every year? I do not know, it has been a while since I did assisted living." Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013,	0 660		

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0 660	Continued From page 10 indicated baseline TB screening is required for all health care workers. 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 TB blood test (IGRA). An employee may begin working with patients after a negative TB symptom screen (i.e., no symptoms of active TB disease) and a negative IGRA or TST (i.e., first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients. The Licensee's undated Tuberculosis Screening Policy, read, " 1. The health screening will be completed by a licensed professional before resident contact. Health screening will occur after a conditional offer of employment is made. Repeat testing will be required if deemed necessary by the health care professional for individuals with signs of communicable disease. The nurse manager/designee will be responsible for assuring testing is completed and for any necessary follow-up. This will include any necessary training of supervisors and employees. 2. For all employees, volunteers or contract personnel providing direct resident care, there shall be evidence of baseline TB screening consisting of two components: a. Assessing for current symptoms of active TB disease, (see Baseline TB Screening Tool in Sample Forms) and	0 660		

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0 660	Continued From page 11 b. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step tuberculin skin test (TST) or a single TB blood test. If the employee has proof of a TB blood test or negative Chest X-ray within 90 days of employment, it does not have to be repeated at the time of hire. c. Employee history of BCG vaccination should be disregarded when administering and interpreting TST results." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 720 SS=F	144G.43 Subd. 2 Access to records The facility must ensure that the appropriate records are readily available to employees and contractors authorized to access the records. Resident records must be maintained in a manner that allows for timely access, printing, or transmission of the records. The records must be made readily available to the commissioner upon request. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure records were readily available to employees authorized to have access, including maintaining records in a manner allowing for timely access of the records for a survey. This had the potential to affect all residents and facility staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 720		

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0 720	Continued From page 12 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: R1 was admitted to the licensee on June 9, 2025, with diagnoses including post-traumatic stress disorder, pelvic and perineal pain, and discharged from the licensee on July 14, 2025. R1's Service Plan signed and dated June 12, 2025, indicated R1 received services for bathing assistance, dressing, grooming, medication administration, meal assistance, and mange behavior. On September 30, 2025, at 11:00 a.m., the surveyor inquired about R1's service documentation record. Unlicensed personnel/owner (ULP/O)-D stated, "if it is missing from his [referring to R1] chart, it is not there". The surveyor observed ULP/O-D look in R1's chart and was unable to find the service documentation record. On September 30, 2025, at 11:32 a.m., the surveyor inquired again about R1's service documentation record. ULP/O-D stated, "give me some time, I have to find it, I remember we had a thick book for him that we charted his stuff on daily." On September 30, 2025, at 12:45 p.m., ULP/O-D stated they were unable to find R1's service	0 720		

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0 720	Continued From page 13 documentation record at the moment. ULP/O-D never provided R1's service documentation record to the surveyor. No further information was provided. TIME PERIOD FOR CORRECTIONS: Seven (7) days	0 720		
0 800 SS=F	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 and interview, the licensee failed to maintain 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. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an	0 800		

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0 800	Continued From page 14 isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On October 1, 2025, from 10:00 a.m. to 1:30 p.m., the surveyor toured the facility with licensed assisted living director/unlicensed professional/owner (LALD/ULP/O)-D The following was observed. WALLS: On the 43 side of the facility, in resident room #3 and on the 45 side in the basement bathroom there was a hole in the wall that remained after plumbing work had been completed. Failing ceiling and holes can reduce the fire separation between floors and units. On October 1, 2025, at 12:30 p.m., LALD/ULP/O-D, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) 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	0 810		

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0 810	Continued From page 15 residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 810		

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0 810	Continued From page 16 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On October 1, 2025, from 10:00 a.m. to 1:30 p.m., the surveyor toured the facility with licensed assisted living director/unlicensed professional/owner (LALD/ULP/O)-D. The following was observed., surveyor observed the posted evacuation plans and resident room doors lacked identification of each separate resident rooms. Exit plan diagrams must be correctly labeled to reduce confusion and potential obstructions for egress in a fire or similar emergency. October 1, 2025, LALD/ULP/O-D, provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "For a Fire in our AL", undated, failed to include the following: RESIDENT ACTIONS: The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. UNIQUE AND UNUSUAL RESIDENT NEEDS: The facility is transiting to an electronic care plan	0 810		

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0 810	Continued From page 17 website for standard resident evacuation procedures. Paper care plan was currently being used, no current residents reside at the facility. There was a resident that lived there from June to July of 2025. No documentations were provided for this time period. On October 1, 2025, at 1:30 p.m., LALD/ULP/O-D stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. LALD/ULP/O-D lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. LALD/ULP/O-D stated they were using fire drills as training. No other training documentation was provided. On October 1, 2025, at 12:30 p.m., LALD/ULP/O-D stated they understood the requirements for training residents and staff and would implement a training program that was compliant with statute requirements. DRILLS The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. LALD/ULP/O-D stated they had performed one drill for the 43 side of the duplex in the month of June when they had a resident. LALD/ULP/O-D	0 810		

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0 810	Continued From page 18 provided documentation for a fire drill conducted on 6-30-25 at 2:00 pm. On October 1, 2025, at 12:30 p.m., LALD/ULP/O-D, stated there were no additional documented drills for the facility. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
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 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	01530		

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01530	Continued From page 19 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 interview and record review, the licensee failed to ensure two of two employees (unlicensed personnel (ULP)-A), unlicensed personnel/owner (ULP/O)-D), received at least eight hours of initial dementia care training and two hours of initial mental illness training within 160 working hours of their employment start date. 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:	01530		

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01530	Continued From page 20 R1 was admitted to the licensee On June 9, 2025, and discharged from the licensee on July 14, 2025. ULP-A ULP-A was hired on July 27, 2022, to provide direct care services to residents. ULP-A's employee record included an EduCare (electronic training software) transcript printed on October 2, 2025. The transcript contained five hours of dementia training completed May 25, 2025, through June 8, 2025. ULP-A's employee record lacked evidence to demonstrate ULP-A had received the required eight hours of initial dementia training and two hours of mental illness training. ULP/O-D ULP/O-D was hired on July 27, 2022, to provide direct care services to residents and to provide oversight to the licensee's employee. ULP/O-D's employee record included an EduCare transcript printed on October 2, 2025. The transcript contained five hours of dementia training completed on May 25, 2025. ULP/O-D's employee record lacked evidence to demonstrate ULP/O-D had received the required eight hours of initial dementia training and two hours of mental illness training. On September 30, 2025, at 12:08 p.m., ULP/O-D stated they were covering the shifts along with ULP-A when R1 resided at the licensee's facility. ULP/O-D stated they did not have another employee other than themselves, ULP-A, and RN-E, who provided care to R1.	01530		

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01530	Continued From page 21 On October 2, 2025, at 12:48 p.m., ULP/O-D stated they completed five modules of the dementia training, and they did not pay attention to the hours. ULP/O-D stated, "I will finish up the rest of it, do not worry, I will add to it. I will make sure he [referring to ULP-A] finishes it too." The licensee's undated Dementia Care Training policy indicated supervisors of direct-care staff must have at least eight hours of initial training within 120 working hours of employment start date and must have at least two hours of training on topics related to dementia care for each 12 months of employment. Direct care employees must have completed at least eight hours of initial training on required topics in the 160 hours from employment: Until this training is complete, the employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements or a supervisor meeting the requirements must be available for consultation with the new employee until the training requirement is complete. 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	01610		

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01610	Continued From page 22 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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to conduct a nursing assessment by a registered nurse (RN) of the physical and cognitive needs prior to the date on which a prospective resident executed a contract with a facility or the date on which a prospective resident moved in, whichever was earlier, for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R1 was admitted to the licensee on June 9, 2025,	01610		

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01610	Continued From page 23 with diagnoses including post-traumatic stress disorder, pelvic and perineal pain, and discharged from the licensee on July 14, 2025. R1's Service Plan signed and dated June 12, 2025, indicated R1 received services for bathing assistance, dressing, grooming, medication administration, meal assistance, and mange behavior. R1's record included nursing admission assessment completed on June 12, 2025, three days after R1's admission date. On October 1, 2025, at 9:36 a.m., clinical nurse supervisor (CNS)-C stated sometimes the case mangers admitted residents abruptly without giving the licensee time to complete the admission assessment. CNS-C stated it was not normal practice to complete the admission three days later. CNS-C stated they did not know why R1's assessments were not completed on time as they were out of the country during R1's admission and R1's stay at the licensee's facility. During the survey, the surveyor made multiple unsuccessful attempts to reach registered nurse (RN)-E, who completed the assessment for R1. The licensee's undated Comprehensive Resident Assessment policy of indicated the facility will conduct a nursing assessment prior to the date on which a resident executes a contract with a facility or the day the resident moves in, whichever is earlier. The assessment will be done by a registered nurse and will assess the physical and cognitive needs of the prospective resident and propose a temporary service plan. If necessary, this assessment may be completed	01610		

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01610	Continued From page 24 using telecommunication methods based on practice standards that meet the resident's needs and reflect person centered planning and care delivery. Resident assessment and monitoring must be conducted no more than 14 days after initiation of services. On-going resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. All assessments will be included in the resident record No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01610		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan 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.	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39270	A. BUILDING: _____ B. WING _____	10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IMRAN HEALTHCARE SERVICES LLC	5543 PENN AVENUE SOUTH MINNEAPOLIS, MN 55419

(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
01620	Continued From page 25 (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted a re-assessment no more than 14 calendar days after initiation of services for one of one resident (R1).	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39270	A. BUILDING: _____ B. WING _____	10/02/2025

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01620	Continued From page 26 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: R1 was admitted to the licensee on June 9, 2025, with diagnoses including post-traumatic stress disorder, pelvic and perineal pain, and discharged from the licensee on July 14, 2025. R1's Service Plan signed and dated June 12, 2025, indicated R1 received services for bathing assistance, dressing, grooming, medication administration, meal assistance, and mange behavior. R1's record included nursing admission assessment completed on June 12, 2025, and 14-day assessment completed on July 1, 2025, 5 days past the 14-calendar day requirement after R1's admission assessment was completed. On October 1, 2025, at 9:36 a.m., clinical nurse supervisor (CNS)-C stated they did not know why R1's assessments were not completed on time as they were out of the country during R1's admission and R1's stay at the licensee's facility. During the survey, the surveyor made multiple unsuccessful attempts to reach registered nurse (RN)-E, who completed the assessment for R1.	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39270	A. BUILDING: _____ B. WING _____	10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IMRAN HEALTHCARE SERVICES LLC	5543 PENN AVENUE SOUTH MINNEAPOLIS, MN 55419

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01620	Continued From page 27 The licensee's undated Comprehensive Resident Assessment policy of indicated the facility will conduct a nursing assessment prior to the date on which a resident executes a contract with a facility or the day the resident moves in, whichever is earlier. The assessment will be done by a registered nurse and will assess the physical and cognitive needs of the prospective resident and propose a temporary service plan. If necessary, this assessment may be completed using telecommunication methods based on practice standards that meet the resident's needs and reflect person centered planning and care delivery. Resident assessment and monitoring must be conducted no more than 14 days after initiation of services. On-going resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. All assessments will be included in the resident record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		

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

Imran Healthcare Services LLC
5543 Penn Ave S
Minneapolis, MN 55419
Hennepin County
Parcel:

Phone:

License Info

License: HFID 39270

Risk:
License:
Expires on:
CFPM: Sophia Abdi Ali
CFPM #: CFPM-30445; Exp: 11/23/2027

Inspection Info

Report Number: F1039251145
Inspection Type: Full - Single
Date: 9/30/2025 Time: 10:30:00
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 4
Total Priority 3 Orders: 2
Delivery: Emailed

New Order: 4-200 Equipment Design and Construction
4-204.112A *Priority Level: Priority 3 CFP#: 36*
MN Rule 4626.0620A Provide a temperature measuring device located in the warmest part of mechanically refrigerated units and coolest part of hot food storage units that are capable of measuring air temperature or a simulated product temperature.
COMMENT: 5545 - NO DISPLAY THERMOMETER IN REFRIGERATOR. PROVIDE A DISPLAY THERMOMETER IN REFRIGERATOR TO COMPLY WITH ABOVE RULE BEFORE OPERATING FOOD SERVICE.
Comply By: 10/7/2025 Originally Issued On: 9/30/2025

New Order: 4-300 Equipment Numbers and Capacities
4-302.12B *Priority Level: Priority 2 CFP#: 36*
MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.
COMMENT: 5543 & 5545 - NO FOOD PROBE THERMOMETER IS ON-HAND. COMPLY WITH ABOVE RULE BEFORE OPERATING FOOD SERVICE.
Comply By: 10/7/2025 Originally Issued On: 9/30/2025

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: 5543 & 5545 - NO IRREVERSIBLE TEMPERATURE MEASURING DEVICE FOR TESTING DISHWASHING MACHINES IS ON-HAND. GUIDANCE ON OPTIONS SENT WITH REPORT. COMPLY WITH ABOVE RULE BEFORE OPERATING FOOD SERVICE.
Comply By: 10/7/2025 Originally Issued On: 9/30/2025

New Order: 6-300 Physical Facility Numbers and Capacities
6-301.11 *Priority Level: Priority 2 CFP#: 10*
MN Rule 4626.1440 Provide an adequate supply of hand soap at each handwashing sink or group of 2 adjacent handwashing sinks.
COMMENT: 5545 - NO SOAP AT KITCHEN SINK. COMPLY WITH ABOVE RULE BEFORE OPERATING FOOD SERVICE.
Comply By: 10/7/2025 Originally Issued On: 9/30/2025

New Order: 6-300 Physical Facility Numbers and Capacities
6-301.12 *Priority Level: Priority 2 CFP#: 10*
MN Rule 4626.1445 Provide and maintain a supply of individual disposable towels, a continuous towel system, a heated-air hand drying device, or an approved ambient air temperature hand drying device at each handwashing sink or group of adjacent handwashing sinks.
COMMENT: 5543 & 5545 - NO SUPPLY OF PAPER TOWELS AT KITCHEN SINK. COMPLY WITH ABOVE RULE BEFORE OPERATING FOOD SERVICE.
Comply By: 10/7/2025 Originally Issued On: 9/30/2025

New Order: 6-300 Physical Facility Numbers and Capacities
6-301.14A *Priority Level: Priority 3 CFP#: 10*
MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands.
COMMENT: 5543 & 5545 - NO HANDWASHING REMINDER SIGN AT KITCHEN SINK. DESIGNATE A COMPARTMENT OF SINK FOR HANDWASHING BY POSTING A HANDWASHING REMINDER SIGN BEFORE OPERATING FOOD SERVICE.
Comply By: 10/7/2025 Originally Issued On: 9/30/2025

Food & Beverage General Comment

Establishment is in both halves of a residential duplex with street numbers 5543 and 5545. A separate kitchen is provided in each side of duplex.

No residents have been housed in assisted living establishment at time of inspection.

The inspection was completed with the establishment operator and reviewed with MDH nurse evaluator Dee Mosissa..

The kitchens are of residential build and should serve food for same-day service only. The kitchen finishes and surfaces are in good repair, clean and well maintained.

A residential dishwashing machine is present in each kitchen. Thermo sticker tests of machines with results shared by operator via e-mail show a rinse temperature of at least 160 degrees F for both machines.

Discussed the following with the person-in-charge: minimum cook temps for animal proteins, food source, foodborne illness symptoms and exclusion of ill employees, avoiding bare hand contact with ready to eat foods, handwashing, sanitizing., all orders on this report.

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 F1039251145 from 9/30/2025

Sophia Abdi Ali
operator

Aron Goodner,
Public Health Sanitarian 1
651-201-4910
aron.goodner@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

Imran Healthcare Services LLC
Minneapolis
County/Group: Hennepin County

Inspection Info

Report Number: F1039251145
Inspection Type: Full
Date: 9/30/2025
Time: 10:30:00

FREEZERS: Product/Item/Unit: ; Temperature Process:
Location: at Degrees F.
Comment: FROZEN
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: 5545 REFRIGERATOR**; Temperature Process:** AMBIENT
Location: at 33 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: 5543 REFRIGERATOR**; Temperature Process:** AMBIENT
Location: at 40 Degrees F.
Comment:
Violation Issued?: No