



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

December 15, 2025

Licensee
Adeg Group Home LLC
3229 2nd Avenue South
Minneapolis, MN 55408

RE: Project Number(s) SL36944016

Dear Licensee:

On November 14, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on July 11, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in blue ink, appearing to read 'Jess'.

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

JMD



Protecting, Maintaining and Improving the Health of All Minnesotans

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September 30, 2025

Licensee
ADEG GROUP HOME LLC
3229 2nd Avenue South
Minneapolis, MN 55408

RE: Project Number(s) SL36944016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 11, 2025, 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 - 0330 - 144g.30 Subd. 4 - Information Provided By Facility - \$500.00

St - 0 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - \$500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$1,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

REQUESTING A HEARING

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

To submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: <https://forms.office.com/g/Bm5uQEPhVa>. Your input is important to us and will enable MDH to improve its processes and communication with providers. 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,

A handwritten signature in dark ink, appearing to read 'Jess', with a stylized flourish extending to the right.

Jess Schoenecker, Supervisor

State Evaluation Team

Email: Jess.Schoenecker@state.mn.us

Telephone: 651-201-3789 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36944	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/11/2025
NAME OF PROVIDER OR SUPPLIER ADEG GROUP HOME LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3229 2ND AVENUE SOUTH MINNEAPOLIS, MN 55408		
(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 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#36944016 On July 7, 2024, through July 11, 2025, 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 2 residents; 2 receiving services under the Assisted Living license. An immediate correction order was identified on July 8, 2025, issued for SL36944016-0, tag identification 0775. During the survey, the licensee took action to mitigate the immediate risk for tag identification 0775. However, noncompliance remained, and the scope and level remain unchanged. An immediate correction order was identified on July 10, 2025, issued for SL36944016-0, tag identification 0495.	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 SUBDIVISION 1-3.		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 000	Continued From page 1	0 000			
0 330 SS=F	During the survey, the licensee took action to mitigate the immediate risk for tag identification 0495. However, noncompliance remained, and the scope and level remain unchanged. 144G.30 Subd. 4 Information provided by facility (a) The assisted living facility shall provide accurate and truthful information to the department during a survey, investigation, or other licensing activities. (b) Upon request of a surveyor, assisted living facilities shall within a reasonable period of time provide a list of current and past residents and their legal representatives and designated representatives that includes addresses and telephone numbers and any other information requested about the services to residents. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide the Minnesota Department of Health (MDH) with accurate and truthful information during a survey. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living facility license effective March 5, 2025, with an	0 330			

Minnesota Department of Health

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0 330	Continued From page 2 expiration date of March 4, 2026. LICENSED HEALTH PROFESSIONALS' AVAILABILITY On July 7, 2025, at 10:00 a.m., the surveyor arrived at the licensee's facility to initiate a survey. Owner/unlicensed personnel (O/ULP)-C arrived on site at 10:30 a.m. and stated licensed assisted living director (LALD)-A was unavailable for the next five days. O/ULP-C also stated clinical nurse supervisor (CNS)-B was unavailable to come onsite today and was out of town. O/ULP-C requested to reschedule the survey. On July 7, 2025, at approximately 12:00 p.m., LALD-A arrived on site. EMPLOYEE AND RESIDENT RECORDS On July 7, 2025, at 11:00 a.m., surveyor requested the licensee's employee and resident records. O/ULP-C stated they did not know where the licensee's employee or resident records were located. O/ULP-C requested to reschedule the survey. On July 7, 2025, at approximately 11:30 a.m., O/ULP-A provided the licensee's resident records to the surveyor. RESIDENT CARE BOOK On July 7, 2025, at 11:45 a.m., O/ULP-C provided a binder labeled care book and stated this was where resident cares were documented. Surveyor observed in the resident care book R1's and R2's medication administration record (MAR) lacked medication administration charting for the dates of May 26, 2025, through July 7, 2025.	0 330			

Minnesota Department of Health

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0 330	Continued From page 3 On July 7, 2025, at 3:00 p.m., licensed assisted living director (LALD)-A confirmed the missing medication documentation on R1's and R2's MAR. LALD-A stated R1's and R2's medications were administrated but sometimes the staff forget to mark it down. LALD-A also stated the licensee would remind staff to document all medication administration on residents moving forward. On July 8, 2025, at 10:05 a.m., surveyor observed R1's and R2's MAR for July 1 through July 7, 2025, now indicated R1's and R2's medications were administrated. Surveyor also observed May and June's MARs were missing from the resident care book. BACKUP RN On July 7, 2025, at approximately 10:30 a.m., during the entrance conference, O/ULP-C stated clinical nurse supervisor (CNS)-B was the only RN that worked for the licensee. On July 7, 2025, at approximately 12:10 p.m., LALD-A stated the licensee employed two licensed staff. LALD-A confirmed the two employed licensed staff were LALD-A and CNS-B. On July 7, 2025, at approximately 1:00 p.m., LALD-A provided the surveyor the licensee's employee list. The licensee's employee list indicated one RN, and no backup RN was indicated. On July 7, 2025, at approximately 3:25 p.m., LALD-A stated the licensee had a backup RN for CNS-B. LALD-A also stated the backup RN was an employee for the licensee.	0 330			

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0 330	Continued From page 4 On July 8, 2025, at 10:00 a.m., O/ULP-C provided the surveyor an employee file of a RN that used to work for the previous owner of the facility and O/ULP-C stated this RN could be the backup RN but the licensee would have to hire this RN. The employee file indicated that there was no entries or annual training since 2022. On July 8, 2025, at approximately 10:10 a.m., CNS-B confirmed CNS-B was the only RN that currently worked for the licensee. CNS-B stated CNS-B had requested the licensee to hire a backup RN to help cover for sick time or days off needed for CNS-B, but the licensee had not hired a backup RN yet. Throughout the survey, the surveyor was given different information regarding LALD-A's availability, employee and resident records access, MAR documentation, and RN backup employee status. The licensee's 2.35 Resident Record - Access & Storage policy dated March 1, 2023, indicated licensee resident records would be made available to MDH as requested. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 330			
0 450 SS=A	144G.41 Subdivision 1 Minimum requirements All assisted living facilities shall: (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171	0 450			

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0 450	Continued From page 5 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide the current assisted living bill of rights (ALBOR) to one of two residents (R1). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 admitted on June 23, 2023. R1's record lacked evidence R1 was provided the ALBOR. On July 7, 2025, at approximately 3:30 p.m., licensed assisted living director (LALD)-A acknowledged the ALBOR was not provided and documented as received in R1's record and was unsure why. LALD-A also stated the licensee would need to provide and document receipt of	0 450			

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0 450	Continued From page 6 current ALBOR to R1. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 450			
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 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;	0 470			

Minnesota Department of Health

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0 470	Continued From page 7 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure a current staffing schedule was posted as required, potentially affecting all the licensee's current 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) 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 July 7, 2025, at approximately 12:30 p.m., during a tour of the facility, the surveyor observed a posted staff schedule with the dates of June 9th through June 23rd. The licensee lacked a current posted daily staffing schedule after redacting direct-care staff member's resident assignments, at the beginning of each work shift in a central location. On July 7, 2025, at approximately 12:35 p.m., licensed assisted living director (LALD)-A acknowledged the staffing schedule was not current and was unsure why it was not updated by the house manager. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470			

Minnesota Department of Health

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0 480	Continued From page 8	0 480			
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink;	0 480			

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0 480	Continued From page 9 (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated July 8, 2025, for the specific Minnesota Food Code violations. The Inspection	0 480			

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0 480	Continued From page 10 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			
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services (a) All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a menu was prepared a week in advance and made available to the residents. This had the potential to affect all current residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not	0 485			

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NAME OF PROVIDER OR SUPPLIER ADEG GROUP HOME LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3229 2ND AVENUE SOUTH MINNEAPOLIS, MN 55408			
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0 485	Continued From page 11 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 the residents). The findings include: On July 7, 2025, at approximately 12:15 p.m., during entrance conference, licensed assisted living director (LALD)-A stated the licensee provided three meals daily and snacks twice daily. On July 7, 2025, at approximately 12:40 p.m., during a facility tour the surveyor observed a well-used, undated menu with multiple pin holes on top of the form. Surveyor asked LALD-A if this menu was reused every week and if the same food is provided to residents each week. On July 7, 2025, at approximately 12:45 p.m., LALD-A stated the licensee served different food every week and was not aware a current menu must be prepared at least one week in advance and made available to all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485			
0 495 SS=F	144G.41 Subdivision. 1 (13) Minimum Requirements (13) provide staff access to an on-call registered nurse 24 hours per day, seven days per week. This MN Requirement is not met as evidenced	0 495			

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0 495	Continued From page 12 by: Based on observation, interview, and record review, the licensee failed to provide staff access to an on-call registered nurse (RN) 24 hours a day, when the licensee hired clinical nurse supervisor (CNS)-B to perform all nursing tasks and CNS-B simultaneously enrolled in a nursing master's degree program that required CNS-B to complete clinical hours which would not allow them to be available 24 hours per day, 7 days per week, to address the licensee's emergencies or concerns. This had the potential to affect all residents and staff. 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: The licensee held an assisted living facility license staffed with eight personnel - licensed assisted living director (LALD)-A, CNS-B, owner/unlicensed personnel (O/ULP)-C, and five other ULPs. The licensee was licensed for a bed capacity of five residents and had a current census of two residents. On July 7, 2025, at approximately 10:30 a.m., during the entrance conference, O/ULP-C stated CNS-B was on-site for one day a week and available via telephone around the clock. O/ULP-C also stated CNS-B was unavailable	0 495	During the survey, the licensee took action to mitigate the immediate risk for tag identification 0495. However, noncompliance remained, and the scope and level remain unchanged.		

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0 495	Continued From page 13 today because CNS-B was out of town. O/ULP-C further stated CNS-B was the only RN that worked for the licensee and never had an issue reaching CNS-B. On July 7, 2025, at 11:42 a.m., per phone interview, CNS-B stated she was currently enrolled in a nursing master's degree program that required 160 hours of clinicals in three months. CNS-B also stated she was unable to come on site today for the survey because today's clinical didn't end until 5:30 p.m. and the clinical was located approximately a 90-minute drive from the facility. On July 7, 2025, at approximately 12:10 p.m., LALD-A stated the licensee employed two licensed staff. LALD-A confirmed the two employed licensed staff are LALD-A and CNS-B. On July 7, 2025, at approximately 1:00 p.m., LALD-A provided the surveyor the licensee's employee list. The licensee's employee list indicated one RN, and no backup RN was indicated. On July 7, 2025, at approximately 3:25 p.m., LALD-A stated the licensee had a backup RN for CNS-B. LALD-A also stated the backup RN was an employee for the licensee. On July 8, 2025, at 10:00 a.m., O/ULP-C provided the surveyor an employee file of a RN that used to work for the previous owner of the facility and O/ULP-C stated this RN could be the backup RN but the licensee would have to hire this RN. The employee file indicated that there was no entries or annual training since 2022.	0 495			

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0 495	Continued From page 14 On July 8, 2025, at approximately 10:10 a.m., CNS-B confirmed CNS-B was the only RN that currently worked for the licensee. CNS-B stated CNS-B had requested the licensee to hire a backup RN to help cover for sick time or days off needed for CNS-B, but the licensee had not hired a backup RN yet. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	0 495			
0 500 SS=F	144G.41 Subd. 2 Policies and procedures Each assisted living facility must have policies and procedures in place to address the following and keep them current: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (2) conducting and handling background studies on employees; (3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (4) handling complaints regarding staff or services provided by staff; (5) conducting initial evaluations of residents' needs and the providers' ability to provide those services; (6) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (7) orientation to and implementation of the assisted living bill of rights; (8) infection control practices;	0 500			

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0 500	Continued From page 15 (9) reminders for medications, treatments, or exercises, if provided; (10) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; (11) ensuring that nurses and licensed health professionals have current and valid licenses to practice; (12) medication and treatment management; (13) delegation of tasks by registered nurses or licensed health professionals; (14) supervision of registered nurses and licensed health professionals; and (15) supervision of unlicensed personnel performing delegated tasks. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement current policies and procedures as required. This had the potential to affect all current 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 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: On July 7, 2025, at 9:11 a.m., the surveyor	0 500			

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0 500	Continued From page 16 emailed the licensee that an onsite assisted living facility survey would be initiated on July 7, 2025, at approximately 10:00 a.m. The email indicated the licensee's policies and procedures would need to be available for review. The licensee failed to provide the following policies and procedures during the survey process: -conducting and handling background studies on employees; -orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; -conducting initial evaluations of residents' needs and providers' ability to provide those services; -conducting initial and ongoing resident evaluations and assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; -orientation to and implementation of the assisted living bill of rights; -infection control practices; -conducting appropriate screenings, or documentation of prior screenings, to show staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; -ensuring that nurses and licensed health professionals have current and valid licenses to practice; -supervision of registered nurses and licensed health professionals; and -supervision of unlicensed personnel performing delegated tasks. On July 7, 2025, at 10:05 a.m., during the	0 500			

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0 500	Continued From page 17 entrance conference the surveyor requested policies and procedures from owner/unlicensed personnel (O/ULP)-C. O/ULP-C stated was unaware of any required policies. On July 7, 2025, at 12:05 p.m., the surveyor requested policies and procedures from licensed assisted director (LALD)-A. LALD-A stated the policy binder should be around here somewhere. On July 7, 2025, at 3:30 p.m., LALD-A stated the licensee would contact the house manager on where the policies are located. On July 8, 2025, at 9:30 a.m., O/ULP-C stated the licensee lacked the required policies and the licensee would have to make them. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 500			
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	0 550			

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0 550	Continued From page 18 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 and contact information for the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. This had the potential to affect all the licensee's current 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: During a facility tour on July 7, 2025, at approximately 12:30 p.m., the common areas shared by residents, staff, and visitors, lacked a posting of the grievance procedure to include the name, telephone number, and e-mail contact information for the individuals who were responsible for handling resident grievances. On July 7, 2025, at approximately 12:35 p.m., licensed assisted living director (LALD)-A acknowledged the required content was not	0 550			

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0 550	Continued From page 19 posted in the common areas. LALD-A stated this information was posted but had been removed. The licensee lacked a policy related to grievances. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550			
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement and maintain a quality management program (QMP) appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 580			

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0 580	Continued From page 20 safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On July 7, 2025, at approximately 12:20 p.m., during the entrance conference, licensed assisted living director (LALD)-A stated the licensee provided ongoing QMP areas were identified, but no meeting minutes, tracking, or specific improvement projects would be documented. The licensee's Quality Management Program policy undated, indicated a QMP would be implemented, and documentation would be provided upon request. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580			
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules;	0 650			

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0 650	Continued From page 21 (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records contained the required content to include an annual performance evaluation for two of two employees (owner/unlicensed personnel (O/ULP)-C, ULP-D). 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: O/ULP-C O/ULP-C had a hire date of October 4, 2021.	0 650			

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0 650	Continued From page 22 O/ULP-C's employee record did not contain any performance evaluations. ULP-D ULP-D had a hire date of February 14, 2024. ULP-D's employee record did not contain any performance evaluations. On July 7, 2024, at 1:50 p.m., licensed assisted living director (LALD)-A acknowledged O/ULP-C's and ULP-D's employee files lacked documentation of any annual performance reviews and stated wasn't sure if any annual performance reviews were completed for any employee of the licensee. The licensee's 4.05 Employee Records dated March 1, 2023, indicated the licensee's employee records would include documentation of annual performance reviews that identify areas of improvement needed and training needs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650			
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	0 660			

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0 660	Continued From page 23 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 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) when the licensee failed to complete a facility TB risk assessment. 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 June 7, 2025, at approximately 10:00 a.m. during the entrance conference, owner/unlicensed personnel (O/ULP)-C was unaware if the licensee had completed a facility TB risk assessment. On June 7, 2025, at approximately 12:25 p.m.,	0 660			

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0 660	Continued From page 24 licensed assisted living director (LALD)-A stated clinical nurse supervisor (CNS)-B was responsible for completing the facility TB risk assessment. On June 8, 2025, at approximately 9:45 a.m., CNS-B stated a facility TB risk assessment was completed but no documents would be provided. The licensee could not provide any documents that indicated a completed facility TB risk assessment was performed by the licensee for this year or prior years. The licensee lacked a policy related to conducting appropriate screenings, or documentation of prior screenings, to show staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and the CDC guidelines, indicated a TB infection control program should include a facility TB risk assessment. The guidelines also indicated 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. No further information was provided.	0 660			

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0 660	Continued From page 25	0 660			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all visitors, employees, and residents.	0 680			

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0 680	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 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: On July 7, 2025, at approximately 1:00 p.m., licensed assisted living director (LALD)-A provided a binder and stated the contents were the licensee's EPP. The binder indicated the licensee's EPP was a shell and not individualized to the licensee's facility. The licensee's EPP undated, lacked an individualized plan to include all the required content below: -missing annual reviews; -missing resident quarterly review; -missing hazard and vulnerability assessment (HVA); -process for EP collaboration; -development of all policies/procedures (P/P) based on HVA; -development of communication plan; and -EP training and testing program. On July 7, 2025, at approximately 1:45 p.m., LALD-A acknowledged the licensee's EPP lacked the above listed required content. LALD-A stated was not aware of the HVA and all the requirements of Appendix Z.	0 680			

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0 680	Continued From page 27 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680			
0 775 SS=H	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 and interview, the licensee failed to comply with the current State Fire Code in Minnesota Rules, chapter 7511. The licensee failed to provide resident bedrooms with the minimum window opening meeting the minimum state standard for egress. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On July 8, 2025, from 11:00 a.m. to 12:00 p.m., the surveyor toured the facility with owner/unlicensed personnel (O/ULP)-C. During the tour, the surveyor asked O/ULP-C to open	0 775	An immediate correction order was identified on July 8, 2025, issued for SL36944016-0, tag identification 0775. During the survey, the licensee took action to mitigate the immediate risk for tag identification 0775. However, noncompliance remained, and the scope and level remain unchanged.		

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0 775	Continued From page 28 the windows in the resident bedrooms for measurement. The noncompliant measurements were as follows: OCCUPIED SLEEPING ROOMS: Bedroom 1: One windows measuring 24 3/4 inches clear width, 21.25 inches clear height, and 515 square inches total open area. Two window measuring 20.25 inches clear width, 28.75 inches clear height, and 582 square inches total open area. UNOCCUPIED SLEEPING ROOMS: Bedroom 3: One windows measuring 26.5 inches clear width, 22.75 inches clear height, and 603 square inches total open area. One window in closet measuring 23.5 inches clear width, 19 inches clear height, and 446.5 square inches total open area. The windows in bedrooms 1, and 3 did not meet the minimum requirements for total openable area. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. At least one window in each bedroom in a state-licensed facility must meet the minimum state fire code standard for an egress window to be a complying bedroom for resident occupancy. On July 8, 2025, the surveyor explained to O/ULP-C that an immediate correction order was issued for the above findings. O/ULP-C stated they understood the requirements for egress	0 775			

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0 775	Continued From page 29 windows and would start the process of getting the windows replaced. TIME PERIOD FOR CORRECTION: Immediate.	0 775			
0 780 SS=F	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; This MN Requirement is not met as evidenced by:	0 780			

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0 780	Continued From page 30 Based on observation and interview, the licensee failed to provide smoke alarms that functioned and were interconnected so that the actuation of one alarm caused all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and 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 potential to affect a large portion or all of the residents). The findings include: On July 8, 2025, from 11:00 a.m. to 12:00 p.m., the surveyor toured the facility with owner/unlicensed personnel (O/ULP)-C. The surveyor asked O/ULP-C to initiate a test of the smoke alarms throughout the home. Upon testing, it was found that the smoke alarm in bedroom 4 was not interconnected with the rest of the facility. These deficient conditions were visually verified by O/ULP-C accompanying on the tour. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780			
0 800 SS=E	144G.45 Subd. 2 (a) (4) Fire protection and physical environment	0 800			

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0 800	Continued From page 31 (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, in a continuous state of good repair and operation. 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, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On July 8, 2025, from 11:00 a.m. to 12:00 p.m., the surveyor toured the facility with owner/unlicensed personnel (O/ULP)-C. The following was observed: There were shingles lying on the ground adjacent to the building in the side yard. The surveyor	0 800			

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0 800	Continued From page 32 observed a patch of shingles missing from the roof directly above where the shingles were located on the ground. The overhead light in bedroom 4 was missing the cover. The staff bathroom vanity light fixture was missing light bulbs. The door to bedroom 3 was damaged along the latching side. The strike and latch were loose and the door was split along the edge indicating it had been forced open. The closet light in bedroom 3 did not work. The carpeting in bedrooms 1, 2, and 3 had significant soiling and burn marks. O/ULP-C stated the carpet was in that condition when they purchased the company. The surveyor could not access the attached bathroom in bedroom 3. O/ULP-C stated they did not have a key for that room. The exterior wall finish was bulging, cracked, and damaged in multiple locations indicating water penetration and entrapment behind the exterior finish material. The roof fascia was rotting and damaged in multiple locations around the exterior of the building. Portions of the wood were missing at the ends of the roof. These deficient conditions were visually verified by O/ULP-C accompanying on the tour.	0 800			

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0 800	Continued From page 33 The physical environment must be maintained in a continuous state of good repair and operation. No further information was provided. 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 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	0 810			

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0 810	Continued From page 34 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, to provide the required training, and to conduct evacuation drills. 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 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 July 8, 2025, from 11:00 a.m. to 12:00 p.m., the surveyor toured the facility with owner/unlicensed personnel (O/ULP)-C. The surveyor observed the posted evacuation floor plan map did not have room numbers. There were also no room numbers posted on or near each sleeping room. The resident sleeping rooms are required to be identified with a number matching a corresponding number on the posted evacuation floor plan map in order to provide direction to the building occupants and emergency responders in the event of a fire or	0 810			

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0 810	Continued From page 35 similar emergency. On July 8, 2025, O/ULP-C 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, Fire Safety, dated August 1, 2023, failed to include the following: The FSEP failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but the plan was designed for a building with life safety systems such as fire doors and smoke compartments. The policy had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility which did not have life safety systems or a fire-resistant construction type. 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. The FSEP failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include the identification of any residents that needed assistance, any resident-specific procedures to	0 810			

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0 810	Continued From page 36 staff for assisting residents during evacuation, nor did it include instructions for staff to follow in case of relocation. On July 8, 2025, at 1:30 p.m., O/ULP-C stated they didn't understand that the third-party policy they were using was not correct. O/ULP-C stated they would work on bringing them into compliance. The policy reviewed was an unedited policy from a third-party provider that was not specific to the facility. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. O/ULP-C 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. O/ULP-C lacked documentation showing any training was completed or training was scheduled for a future date for employees on the fire safety and evacuation plan. On July 8, 2025, at 1:30 p.m., O/ULP-C stated they could not find the documentation for training because the manager was on vacation. O/ULP-C also stated they were doing the training at the same time as the evacuation drills. Training on the FSEP must be completed separately from the evacuation drills. DRILLS: The licensee failed to conduct evacuation drills for employees twice per year, per shift with at	0 810			

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0 810	Continued From page 37 least one evacuation drill every other month. O/ULP-C lacked documentation showing any evacuation drills were conducted. On July 8, 2025, at 1:30 p.m., O/ULP-C stated they could not find the documentation for evacuation drills because the manager was on vacation. O/ULP-C also stated they thought evacuation drills were conducted every other month or quarterly. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a	0 970			

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0 970	Continued From page 38 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 July 7, 2025, at approximately 1:15 p.m., licensed assisted living director (LALD)-A provided a resident's (R1) Assisted Living Contract and stated the contract was used by licensee for all residents who would live in the facility. The licensee's Assisted Living Contract, dated June 23, 2023, on page 14, included a section titled Indemnification and read, "[Licensee] shall not be liable for any damage or injury to the resident, or any other person, or to any property, occurring on the premises, or any part thereof, or in common areas thereof, and the resident agrees to hold [licensee] harmless from any claims or damages unless caused solely by negligence of [licensee]." On July 7, 2025, at approximately 2:00 p.m., LALD-A acknowledged the licensee's assisted living contract included a waiver of liability for health and safety or personal property of the resident. LALD-A stated the liability waiver would need to be removed from the licensee's contracts. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970			

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01500	Continued From page 39	01500			
01500 SS=F	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 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.	01500			

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01500	Continued From page 40 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 interview and record review, the licensee failed to ensure an employee received at least eight hours of annual training for each 12 months of employment for two of two employees (owner/unlicensed personnel (O/ULP)-C, ULP-D). 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:	01500			

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01500	Continued From page 41 O/ULP-C had a hire date of October 4, 2021, and ULP-D had a hire date of February 14, 2024. O/ULP-C and ULP-D's training records lacked evidence of the eight hours annual training requirement to include all the required content below: -Reporting maltreatment of vulnerable adults or minors; -Assisted Living Bill of Rights; -Infection control techniques; -Effective approaches to use to problems 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 provider's policies and procedures; -Principles of person-centered planning/service delivery; -Dementia training two hours; and -Mental Illness and de-escalation training one hour. On July 7, 2025, at 12:45 p.m., licensed assisted living director (LALD)-A stated O/ULP-C and ULP-D did not complete the required annual training and was unaware of all the required annual training content. LALD-A also stated no other employees of the licensee completed the required annual training. LALD-A further stated would ensure all the required annual training for employees would be completed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500			

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01530	Continued From page 42	01530			
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 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	01530			

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01530	Continued From page 43 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 all employees received eight hours of initial dementia care training within the first 160 working hours of employment for direct care employees as required for two of two employees (owner/unlicensed personnel (O/ULP)-C, ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: O/ULP-C O/ULP-C was hired on October 4, 2021, to provide direct care to the residents. O/ULP-Cs employee record lacked the required eight hours of dementia care training within 160 hours of working for the licensee. ULP-D ULP-D was hired on February 14, 2024, to provide direct care to the residents.	01530			

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01530	Continued From page 44 ULP-D's employee record included the following initial dementia training: -Dementia Management and Abuse Prevention (one hour) completed on February 14, 2024; and -Dementia - Person-Centered Care (one hour) completed on February 14, 2024. ULP-D had a total of two hours completed within 160 hours of working for the licensee. ULP-D's personnel record lacked the required eight hours of dementia care training within 160 hours of working for the licensee. On January 7, 2025, at 3:00 p.m., licensed assisted living director (LALD)-A stated was unsure if O/ULP-C and ULP-D or if any other employee completed the initial dementia care training and would ensure any new employee would be provided eight hours of the initial dementia training. The licensee's 5.03 Dementia Training policy dated March 1, 2023, indicated direct care employees would complete at least eight hours of initial dementia training within 160 working hours of employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			
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	01620			

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01620	Continued From page 45 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. (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	01620			

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01620	Continued From page 46 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 a registered nurse (RN) completed comprehensive assessments to include all required content identified per Minnesota Administrative Rule 4659.0150 Uniform Assessment Tool for two of two residents (R1, 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 potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted on June 23, 2023. R1's 90 Day Assisted Living Reassessment records dated June 20, 2025, March 22, 2025, and December 23, 2024, were two-page documents identified by clinical nurse supervisor (CNS)-B as R1's last three consecutive 90-day RN assessments completed by CNS-B. The assessments lacked a full physical and cognitive	01620			

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01620	Continued From page 47 assessment as required on the uniform assessment tool. R2 R2 was admitted on October 5, 2023. R2's 90 Day Assisted Living Reassessment records dated April 10, 2025, January 10, 2025, and October 12, 2024, were two-page documents identified by CNS-B as R2's last three consecutive 90-day RN assessments completed by CNS-B. The assessments lacked a full physical and cognitive assessment as required on the uniform assessment tool. The assessments failed to be developed and address the required content per Minnesota Administrative Rule 4659.0140 Subpart 2. B. (3). On July 8, 2025, at 10:30 a.m., CNS-B stated licensee performed a comprehensive assessment upon resident admit that included all the elements of the uniform assessment tool, then used the two-page RN assessment for all other assessments and was not aware of the Uniform Assessment Tool requirement for all 90-day assessments. The licensee lacked a policy related to RN assessments. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01690 SS=F	144G.71 Subdivision 1 Medication management services	01690			

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01690	Continued From page 48 (a) This section applies only to assisted living facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and maintain current written medication management policies and procedures under the supervision and direction	01690			

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01690	Continued From page 49 of a registered nurse (RN). 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: During the entrance conference on July 7, 2025, at 12:15 p.m., licensed assisted living director (LALD)-A stated the licensee provided medication management services to the licensee's residents. The licensee's provided policies lacked: - resolving medication errors; and -controlling and storing medications, On July 7, 2025, at 12:05 p.m., the surveyor requested policies and procedures from LALD-A. LALD-A stated the policy binder should be around here somewhere. On July 7, 2025, at 3:30 p.m., LALD-A stated the licensee would contact the house manager on where the policies were located. On July 8, 2025, at 9:30 a.m., owner/unlicensed personnel (O/ULP)-C stated the licensee did not have the required policies and the licensee would have to make them. No further information was provided.	01690			

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01690	Continued From page 50	01690			
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 document administration or refusal of medications according to provider orders for two of two residents (R1, 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 potential to affect a large portion or all of the residents).	01760			

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01760	Continued From page 51 The findings include: R1 R1 was admitted on June 23, 2023. R1's signed Service Plan dated June 23, 2023, indicated R1 received services to include assistance with medications, medication reminders, and medication administration. R1's Nurse Reassessment Visit dated June 20, 2025, indicated licensee staff managed R1's medications. R1's medication administration record (MAR) had missing charting for the dates of May 26, 2025, through July 7, 2025, on the following medications: -trazodone (antidepressant) 150 milligrams (mg) at bedtime; -risperidone (antipsychotic) 6 mg at bedtime; and -divalproex (anticonvulsant) 1500 mg at bedtime. R2 R2 was admitted on October 5, 2023. R2's Signed Service Plan dated October 5, 2023, indicated R2 received services to include assistance with medications, medication reminders, and medication administration. R2's Nurse Reassessment Visit dated April 10, 2025, indicated licensee staff managed R2's medications. R2's MAR had missing charting for the dates of May 26, 2025, through July 7, 2025, on the following medications:	01760			

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NAME OF PROVIDER OR SUPPLIER ADEG GROUP HOME LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3229 2ND AVENUE SOUTH MINNEAPOLIS, MN 55408		
(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 52 -risperidone (antipsychotic) 2 mg at bedtime and 2 mg in the morning; -benztropine (treat stiffness or tremors) 0.5 mg at bedtime; -busprione (anti-anxiety) 10 mg at bedtime and 10 mg in the morning; -amiodipine (treat high blood pressure) 5 mg in the morning; and -lisinopril (treat high blood pressure) 10 mg once daily. On July 7, 2025, at 3:00 p.m., licensed assisted living director (LALD)-A confirmed the missing medication documentation on R1 and R2's MARs. LALD-A stated R1 and R2's medications were administrated but sometimes the staff forget to mark it down. LALD-A also stated the licensee would remind staff to document all medication administration on residents. The licensee's 7.15 Medication & Treatment - Administration & Delegation policy dated March 1, 2023, indicated the staff were trained and competency trained to document medication administration or the reason for not assisting with medication administration as ordered. 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

Page: 1

Establishment Info

Adeg Group Home LLC
3229 2nd Ave S
Minneapolis, MN 55408
Hennepin County
Parcel:

Phone:

License Info

License: HFID 36944

Risk:
License:
Expires on:
CFPM: MOHAMED Y. ABDULAH
CFPM #: 108981; Exp: 12/20/2027

Inspection Info

Report Number: F1029251059
Inspection Type: Full - Single
Date: 7/8/2025 Time: 11:46:37 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 4
Total Priority 2 Orders: 7
Total Priority 3 Orders: 6
Delivery:

New Order: 2-100 Supervision

2-102.12FMN Priority Level: Priority 3 CFP#: 2

MN Rule 4626.0033F The certified food protection manager must identify the hazards in the operation of the food establishment; develop or implement policies, procedures, or standards to prevent foodborne illness in the food establishment; coordinate training, supervision or direction of food preparation activities; take corrective action in the food establishment as needed to protect the health of the consumer; and, complete in-house self-inspections of the daily operations in the food establishment at a frequency that ensures food safety policies and procedures are followed.
COMMENT: ADEQUATE FOOD SAFETY TRAINING NOT BEING ADMINISTERED BY ESTABLISHMENT'S CFPM.
OPERATOR INSTRUCTED TO ENSURE CFPM IS ONSITE OFTEN ENOUGH TO PROVIDE ADEQUATE FOOD SAFETY TRAINING TO PROVIDE OVERSIGHT TO PREVENT FOODBORNE ILLNESS RISK FACTORS.

Comply By: 7/11/2025 Originally Issued On: 7/8/2025

New Order: 2-100 Supervision

2-103.11D,G,H,I,K,M Priority Level: Priority 2 CFP#: 1

MN Rule 4626.0035DGHKIM The person in charge must ensure employees follow proper food handling procedures, including: effectively wash their hands; prevent cross-contamination of ready-to-eat food with bare hands by using suitable food utensils such as deli tissue, spatulas, tongs, single-use gloves, or proper dispensing equipment; properly cook TCS foods and verify cooking temperatures with a temperature measuring device; properly cool TCS foods that will not be held hot or consumed within 4 hours; maintain TCS foods at proper hot and cold holding temperatures; plumbing cross connection control, and properly sanitize cleaned multiuse equipment and utensils by monitoring the exposure time and concentration of the chemical sanitizing rinse solution, or by monitoring the exposure time and temperature for hot water sanitizing.

COMMENT: OPERATOR UNAWARE OF SAFE COOK TEMPERATURES, SAFE SANITIZING CONCENTRATIONS, AND THE REQUIREMENT FOR SANITIZING. OPERATOR INSTRUCTED TO COORDINATE WITH CFPM TO ENSURE ADEQUATE FOOD SAFETY TRAINING IS PROVIDED.

Comply By: 7/11/2025 Originally Issued On: 7/8/2025

! New Order: 2-200 Employee Health

2-201.11C Priority Level: Priority 1 CFP#: 3

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.

COMMENT: NO EMPLOYEE ILLNESS LOG. OPERATOR INSTRUCTED TO MAINTAIN EMPLOYEE ILLNESS LOG.
LOGGING REQUIREMENTS REVIEWED.

Comply By: 7/8/2025 Originally Issued On: 7/8/2025

New Order: 2-500 Cleanup of Vomiting and Diarrheal Events2-501.11 *Priority Level: Priority 2 CFP#: 5*

MN Rule 4626.0123 Provide employees with procedures to follow for cleanup of vomit or fecal matter in the establishment. The procedures must minimize the spread of contamination to food and surfaces within the facility, and minimize the exposure of employees and consumers to contamination.

COMMENT: CORRECT STEPS FOR VOMIT/FECAL MATTER CLEAN UP NOT KNOWN. VOMIT/FECAL MATTER CLEAN UP STEPS REVIEWED. OPERATOR INSTRUCTED TO ENSURE ALL STAFF INVOLVED WITH THE FOOD AND BEVERAGE SERVICE ARE AWARE OF HOW TO SAFELY CLEAN UP AND DISPOSE OF VOMIT/FECAL MATTER.

Comply By: 7/8/2025 Originally Issued On: 7/8/2025

! New Order: 3-300C Protection from Contamination: equipment/utensils, consumers3-304.11A *Priority Level: Priority 1 CFP#: 15*

MN Rule 4626.0270A Do not allow food to contact surfaces of equipment and utensils that are not cleaned and sanitized.

COMMENT: UNKNOWN CHEMICAL IN SPRAY BOTTLE BEING USED TO SANITIZE FOOD CONTACT SURFACES IN KITCHEN. OPERATOR INSTRUCTED TO USE APPROVED IDENTIFIABLE SANITIZER AND TO USE TEST STRIPS TO VERIFY SAFE CONCENTRATIONS.

Comply By: 7/8/2025 Originally Issued On: 7/8/2025

New Order: 3-500C Microbial Control: date marking3-501.17B *Priority Level: Priority 2 CFP#: 23*

MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.

COMMENT: NO ESTABLISHMENT DATE MARK ON OPEN BAG OF SHREDDED CHEESE. OPERATOR INSTRUCTED TO DATE MARK REQUIRED ITEMS WHEN THEY ARE OPENED.

Comply By: 7/8/2025 Originally Issued On: 7/8/2025

! New Order: 3-500D Microbial Control: disposition of food3-501.18A *Priority Level: Priority 1 CFP#: 23*

MN Rule 4626.0405A Discard all TCS food prepared in the establishment or opened commercially packaged food when the time exceeds 7 days from the preparation or opening date or if the container or package is not marked.

COMMENT: OPEN BAG OF SHREDDED CHEESE WITH NO ESTABLISHMENT DATE MARK AND WITH A MANUFACTURER USE BY DATE OF APRIL 4, 2025. DISCARDED BY OPERATOR. DANGERS OF LISTERIOSIS DISCUSSED.

Comply By: 7/8/2025 Originally Issued On: 7/8/2025

New Order: 4-300 Equipment Numbers and Capacities4-302.13B *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: NO MIN/MAX THERMOMETER OR THERMAL STICKERS TO VERIFY SANITIZING TEMPS IN DISHWASHER. SINGLE STICKER PROVIDED TO OPERATOR TO VERIFY DISHWASHER SANITIZING TEMPS. OPERATOR INSTRUCTED TO PROVIDE MEANS TO TEST THE HIGH WATER TEMP IN THE DISHWASHER.

Comply By: 7/11/2025 Originally Issued On: 7/8/2025

New Order: 4-300 Equipment Numbers and Capacities4-302.14 *Priority Level: Priority 2 CFP#: 48*

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

COMMENT: NO TEST STRIPS TO TEST ONSITE SANITIZER. OPERATOR INSTRUCTED TO USE CORRESPONDING TEST STRIPS FOR ONSITE SANITIZER.

Comply By: 7/8/2025 Originally Issued On: 7/8/2025

New Order: 4-500 Equipment Maintenance and Operation4-501.11AB *Priority Level: Priority 3 CFP#: 47*

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

COMMENT: FRIDGE COOLER TEMP ON CUSP OF SAFE HOLDING. OPERATOR INSTRUCTED TO ADJUST COOLER TO CONTINUOUSLY MAINTAIN ITEMS AT 33-41F.

Comply By: 7/8/2025 Originally Issued On: 7/8/2025

New Order: 4-600 Cleaning Equipment and Utensils4-602.11E *Priority Level: Priority 3 CFP#: 16*

MN Rule 4626.0845E Clean surfaces contacting food that is not TCS: 1. at any time when contamination may have occurred; 2. at least once every 24 hours for iced tea dispensers and consumer self-service utensils; 3. before restocking consumer self-service equipment and utensils such as condiment dispensers, and display containers; 4. at a frequency specified by the manufacturer or at a frequency necessary to preclude accumulation of soil or mold for ice bins, beverage dispensing nozzles, enclosed components of ice makers, cooking oil storage tanks and distribution lines, beverage and syrup dispensing lines or tubes, coffee bean grinders, and water vending equipment.

COMMENT: HANDWASHING SIGN TAPED TO COUNTER ON COUNTER AREA IN FRONT OF SINK. BUILDUP OF MOLD AND RESIDUE UNDER AND AROUND TAPE. OPERATOR INSTRUCTED TO POST THE SIGN HIGHER UP WAY FROM SPLASH AND SPILLAGE.

Comply By: 7/8/2025 Originally Issued On: 7/8/2025

! New Order: 4-700 Sanitizing Equipment and Utensils4-702.11 *Priority Level: Priority 1 CFP#: 16*

MN Rule 4626.0900 Sanitize utensils and food contact surfaces of equipment before use, after cleaning.

COMMENT: SANITIZING DISHWASHER PRESENT BUT NOT USED BY ESTABLISHMENT. ESTABLISHMENT JUST WASHING, RINSING, AND AIR DRYING EQUIPMENT AND UTENSILS USING 2-COMP KITCHEN SINK. OPERATOR INSTRUCTED TO DISCONTINUE PRACTICE AND TO SANITIZE USING DISHWASHER.

Comply By: 7/8/2025 Originally Issued On: 7/8/2025

New Order: 6-300 Physical Facility Numbers and Capacities6-301.12C *Priority Level: Priority 2 CFP#: 10*

MN Rule 4626.1445C Provide and maintain at each handwash sink in toilet rooms and other areas that are not used for food preparation or warewashing, a supply of individual disposable towels, a continuous towel system that supplies the user with a clean towel, or a heated hand drying device.

COMMENT: NO PAPER TOWELS AT HANDWASHING SINKS. OPERATOR INSTRUCTED TO PLACE PAPER TOWELS AT ALL HANDWASHING SINKS.

Comply By: 7/8/2025 Originally Issued On: 7/8/2025

New Order: 6-300 Physical Facility Numbers and Capacities6-301.14A *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: HANDWASHING SIGN ABSENT IN BATHROOM. OPERATOR INSTRUCTED TO POST HANDWASHING SIGNS AT ALL HANDWASHING STATIONS THAT INDIVIDUALS INVOLVED IN THE FOOD SERVICE HAVE ACCESS TO.

Comply By: 7/8/2025 Originally Issued On: 7/8/2025

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control6-501.111ABD *Priority Level: Priority 3 CFP#: 38*

MN Rule 4626.1565ABD Provide control of insects, rodents, and other pests by routinely inspecting incoming food and supply shipments; routinely inspecting the premises for evidence of pests; and eliminating harborage conditions.

COMMENT: FLIES AND ANTS IN KITCHEN AREA. OPERATOR INSTRUCTED TO ENSURE PEST CONTROL MEASURES ARE IMPLEMENTED TO DETER PEST INTRUSION INTO FOOD SERVICE AREAS.

Comply By: 7/8/2025 Originally Issued On: 7/8/2025

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.16 *Priority Level: Priority 3 CFP#: 55*

MN Rule 4626.1540 Hang mops to dry after each use and do not store mops in a manner that will soil walls, equipment or supplies.

COMMENT: MOP STILL IN MOP WATER. OPERATOR INSTRUCTED TO HANG MOPS TO AIR DRY AFTER EACH USE.

Comply By: 7/8/2025 Originally Issued On: 7/8/2025

New Order: 7-100 Toxic Labeling

7-101.11 *Priority Level: Priority 2 CFP#: 28*

MN Rule 4626.1590 Discontinue use of containers of poisonous, toxic materials, and personal care items that do not bear a legible manufacturer's label.

COMMENT: SPRAY BOTTLES WITHOUT ANY IDENTIFIERS ON BOTTLES TO IDENTIFY SUBSTANCES WITHIN BOTTLES. OPERATOR INSTRUCTED TO ENSURE ALL SANITIZERS AND OTHER CHEMICALS REMOVED FROM THEIR ORIGINAL CONTAINERS ARE LABELED SO THEY ARE IDENTIFIABLE.

Comply By: 7/8/2025 Originally Issued On: 7/8/2025

Food & Beverage General Comment

FOOD AND BEVERAGE INSPECTION CONDUCTED AS PART OF HRD SURVEY OF ASSISTED LIVING FACILITY. INSPECTION CONDUCTED IN THE PRESENCE OF YASIN FATAH, OWNER OPERATOR. ALL IDENTIFIED ISSUES REVIEWED WITH YASIN THROUGHOUT THE INSPECTION. EMPLOYEE ILLNESS LOG AND OTHER FOOD SAFETY MATERIALS PROVIDED WITH 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 F1029251059 from 7/8/2025

YASIN FATAH
OWNER OPERATOR

Trevor McCliment

Trevor McCliment,
Public Health Sanitarian 3
651-201-3957
trevor.mccliment@state.mn.us



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

Temperature Observations/Recordings

Page: 1

Establishment Info

Adeg Group Home LLC
Minneapolis
County/Group: Hennepin County

Inspection Info

Report Number: F1029251059
Inspection Type: Full
Date: 7/8/2025
Time: 11:46:37 AM

New Record: Product/Item/Unit: MILK JUG 1; **Temperature Process:** COLD HOLDING

Location: FRIDGE at 42 Degrees F.

Comment:

Violation Issued?: No

New Record: Product/Item/Unit: MILK JUG 2; **Temperature Process:** COLD HOLDING

Location: FRIDGE at 42 Degrees F.

Comment:

Violation Issued?: No

New Record: Product/Item/Unit: MILK JUG 3; **Temperature Process:** COLD HOLDING

Location: FRIDGE at 42 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

Page: 1

Establishment Info

Adeg Group Home LLC
Minneapolis
County/Group: Hennepin County

Inspection Info

Report Number: F1029251059
Inspection Type: Full
Date: 7/8/2025
Time: 11:46:37 AM

Sanitizing Equipment: Product: Hot Water; **Sanitizing Process:** Dish Machine
Location: Kitchen **Greater Than** 150 Degrees F.
Comment:
Violation Issued?: No

Food Establishment Inspection Report

 Metro District Office Minnesota Department of Health 625 Robert St N, PO BOX 64975 St Paul, MN 55164	No. of Risk Factor/Intervention/Violations		8	Date: 7/8/2025
	No. of Repeat Risk Factor/Intervention/Violations			Time: 11:46:37 AM
	Score (optional)			Dur: min
Establishment: Adeg Group Home LLC	Address: 3229 2nd Ave S	City/State: Minneapolis, MN	Zip: 55408	Phone:
License/Permit #: HFID 36944	Permit Holder:	Purpose of Inspection: Full	Est. Type:	Risk Category:

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Designated compliance status (IN, OUT, N/O, N/A) for each numbered item

IN=in compliance OUT=not in compliance N/O=not observed N/A=not applicable

Mark "X" in appropriate box for COS and/or R

COS=corrected on-site during inspection R=repeat violation

Compliance Status			COS	R
Supervision				
1	OUT	Person in charge present, demonstrate knowledge and performs duties		
2	OUT	Certified Food Protection Manager		
Employee Health				
3	OUT	knowledge, responsibilities, and reporting		
4	IN	Proper use of restriction and exclusion		
5	OUT	Response to vomiting, diarrheal events		
Good Hygienic Practices				
6	N/O	Proper eating, tasting, drinking, tobacco use		
7	IN	No discharge from eyes, nose, and mouth		
Preventing Contamination by Hands				
8	N/O	Hands clean and properly washed		
9	N/O	No bare hand contact with RTE foods, alternatives		
10	OUT	Adequate handwashing sinks supplied and access		
Approved Source				
11	IN	Food obtained from approved source		
12	N/O	Food Received at proper temperature		
13	IN	Food in good condition, safe & unadulterated		
14	N/A	Records available: shellstock tags, parasite dest.		
Protection From Contamination				
15	OUT	Food separated and protected		
16	OUT	Food-contact surfaces; cleaned & sanitized		
17	IN	Proper Disposition of returned, previously served, reconditioned, & unsafe food		

Compliance Status			COS	R
Time/Temperature Control for Safety				
18	N/O	Proper cooking time & temperatures		
19	N/O	Proper reheating procedures for hot holding		
20	N/O	Proper cooling time and temperature		
21	N/O	Proper hot holding temperatures		
22	IN	Proper cold holding temperatures		
23	OUT	Proper date marking & disposition		
24	N/A	Time as public health control; procedures & record		
Consumer Advisory				
25	N/A	Consumer advisory provided for raw or undercooked foods		
Highly Susceptible Populations				
26	IN	Pasteurized foods used; prohibited foods not offered		
Food/Color Additives and Toxic Substances				
27	N/A	Food additives; approved & properly used		
28	OUT	Toxic substances properly identified; stored; used		
Conformance with Approved Procedures				
29	N/A	Compliance with variance, specialized processes & HACCP plan		

Risk factors are improper practices or procedures identified as the most prevalent contributing factors of foodborne illness or injury. Public Health Interventions are control measures to prevent foodborne illness or injury

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" or OUT in box if numbered item is **not** in compliance Mark "X" in appropriate box for COS and/or R COS=corrected on-site during inspection R=repeat violation

			COS	R
Safe Food and Water				
30	N/A	Pasteurized eggs used where required		
31		Water & ice from approved source		
32	N/A	Variance obtained for specialized processing methods		
Food Temperature Control				
33		Proper cooling methods used; adequate equipment for temperature control		
34	N/O	Plant food properly cooked for hot holding		
35	N/O	Approved thawing methods used		
36		Thermometers provided & accurate		
Food Identification				
37		Food properly labeled; original container		
Prevention of Food Contamination				
38	X	Insects, rodents, & animals not present; no unauthorized person		
39		Contamination prevented during food prep, storage, & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
Proper Use of Utensils				
43		In-use utensils; Properly stored		
44		Utensils, equipment & linens; properly stored, dried, handled		
45		Single-use & single-service articles, properly stored and used		
46		Gloves used properly		
Utensils, Equipment and Vending				
47	X	Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48	X	Warewashing facilities: installed, maintained, used; test strips		
49		Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities; properly constructed, supplied & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55	X	Physical facilities installed, maintained & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing and plan review		

Inspector (signature)	<i>Trevor McClime</i>	Follow-up:	Follow-up Date:
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