



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

January 27, 2026

Licensee

Amran Home Health Care LLC
3228 Columbus Avenue South
Minneapolis, MN 55407

RE: Project Number(s) SL36732016

Dear Licensee:

On December 23, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on September 10, 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 black ink that reads 'Stephanie Jones de Palma'.

Stephanie Jones de Palma, Supervisor
State Engineering Services Section
Email: stephanie.jones.de.palma@state.mn.us
Telephone: 651-201-4320 Fax: 1-800-337-9238 / 1-866-890-9290

CLN



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 30, 2025

Licensee

Amran Home Health Care LLC
3228 Columbus Avenue South
Minneapolis, MN 55407

RE: Project Number(s) SL36732016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 10, 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 - 0340 - 144g.30 Subd. 5 - Correction Orders - \$500.00

St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - \$1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$1,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

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

To submit a hearing request, please visit:

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

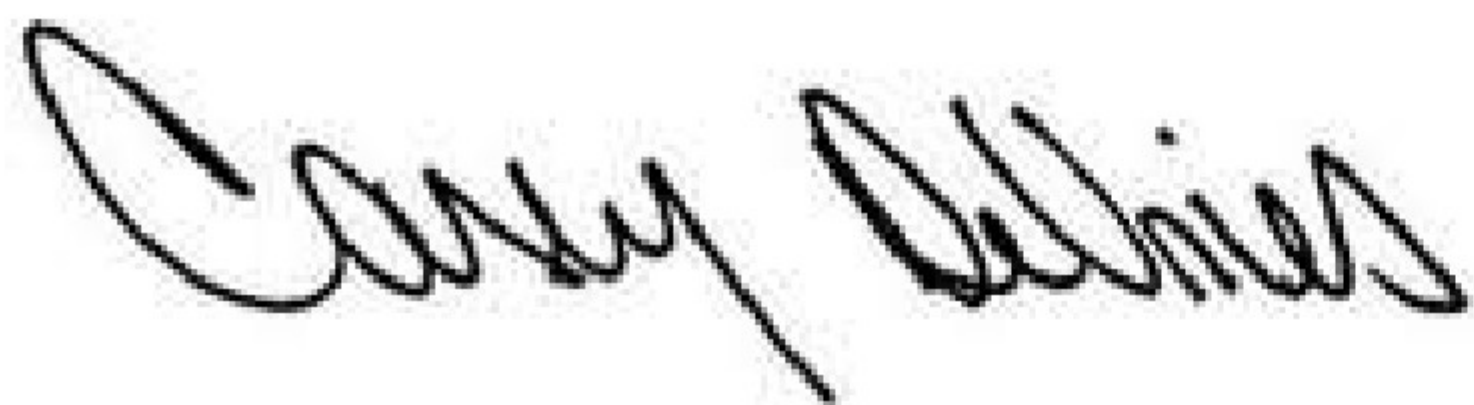
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: <https://forms.office.com/g/Bm5uQEPhVa>. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor

State Evaluation Team

Email: Casey.DeVries@state.mn.us

Telephone: 651-201-5917 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36732	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/10/2025
NAME OF PROVIDER OR SUPPLIER AMRAN HOME HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3228 COLUMBUS AVENUE SOUTH MINNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL36732016-0 On September 8, 2025, through September 10, 2025, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there was one resident, and the one resident was receiving services under the Assisted Living license. An immediate correction order was identified on September 8, 2025, issued for SL36732016-0, tag identification 1290. During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.		
0 130 SS=C	144G.12, Subd. 1 Application for Licensure	0 130			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 130	Continued From page 1 Each application for an assisted living facility license, including provisional and renewal applications, must include information sufficient to show that the applicant meets the requirements of licensure, including: (1) the business name and legal entity name of the licensee, and the street address and mailing address of the facility; (2) the names, e-mail addresses, telephone numbers, and mailing addresses of all owners, controlling individuals, managerial officials, and the assisted living director; (3) the name and e-mail address of the managing agent and manager, if applicable; (4) the licensed resident capacity and the license category; (5) the license fee in the amount specified in section 144.122; (6) documentation of compliance with the background study requirements in section 144G.13 for the owner, controlling individuals, and managerial officials. Each application for a new license must include documentation for the applicant and for each individual with five percent or more direct or indirect ownership in the applicant; (7) evidence of workers' compensation coverage as required by sections 176.181 and 176.182; (8) documentation that the facility has liability coverage; (9) a copy of the executed lease agreement between the landlord and the licensee, if applicable; (10) a copy of the management agreement, if applicable; (11) a copy of the operations transfer agreement or similar agreement, if applicable; (12) an organizational chart that identifies all organizations and individuals with an ownership	0 130			

Minnesota Department of Health

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0 130	Continued From page 2 interest in the licensee of five percent or greater and that specifies their relationship with the licensee and with each other; (13) whether the applicant, owner, controlling individual, managerial official, or assisted living director of the facility has ever been convicted of: (i) a crime or found civilly liable for a federal or state felony level offense that was detrimental to the best interests of the facility and its resident within the last ten years preceding submission of the license application. Offenses include: felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions; financial crimes such as extortion, embezzlement, income tax evasion, insurance fraud, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions; any felonies involving malpractice that resulted in a conviction of criminal neglect or misconduct; and any felonies that would result in a mandatory exclusion under section 1128(a) of the Social Security Act; (ii) any misdemeanor conviction, under federal or state law, related to: the delivery of an item or service under Medicaid or a state health care program, or the abuse or neglect of a patient in connection with the delivery of a health care item or service; (iii) any misdemeanor conviction, under federal or state law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service; (iv) any felony or misdemeanor conviction, under federal or state law, relating to the interference with or obstruction of any investigation into any criminal offense described in Code of Federal	0 130			

Minnesota Department of Health

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0 130	Continued From page 3 Regulations, title 42, section 1001.101 or 1001.201; (v) any felony or misdemeanor conviction, under federal or state law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance; (vi) any felony or gross misdemeanor that relates to the operation of a nursing home or assisted living facility or directly affects resident safety or care during that period; (vii) any revocation or suspension of a license to provide health care by any state licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a state licensing authority; (viii) any revocation or suspension of accreditation; or (ix) any suspension or exclusion from participation in, or any sanction imposed by, a federal or state health care program, or any debarment from participation in any federal executive branch procurement or nonprocurement program; (14) whether, in the preceding three years, the applicant or any owner, controlling individual, managerial official, or assisted living director of the facility has a record of defaulting in the payment of money collected for others, including the discharge of debts through bankruptcy proceedings; (15) the signature of the owner of the licensee, or an authorized agent of the licensee; (16) identification of all states where the applicant or individual having a five percent or more ownership, currently or previously has been licensed as an owner or operator of a long-term care, community-based, or health care facility or agency where its license or federal certification has been denied, suspended, restricted,	0 130			

Minnesota Department of Health

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0 130	Continued From page 4 conditioned, refused, not renewed, or revoked under a private or state-controlled receivership, or where these same actions are pending under the laws of any state or federal authority; (17) statistical information required by the commissioner; and (18) any other information required by the commissioner. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to meet the requirements of licensure for the assisted living license they possessed when the licensed assisted living director (LALD) was living at the assisted living facility. 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 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: The licensee's assisted living (AL) license effective December 1, 2024, indicated a capacity of 10 assisted living residents. The licensee's Application for Assisted Living License indicated 10 assisted living residents and was signed by LALD-D on November 1, 2024. On September 8, 2025, at 11:55 a.m., during the facility tour the surveyor observed a furnished bedroom located in the basement. The surveyor observed a four-poster bed with at least five	0 130			

Minnesota Department of Health

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0 130	Continued From page 5 clothing items on hangers hanging from the bed connector on the left side of the bed. There was a dresser and bedside table with bedside lamp on the right side of the bed. On the dresser was sewing kit, paper towels, food items, water bottle, first aid kit, candles, toiletry items such as lotion, perfume, and others. There was a personal handbag and exercise equipment on the floor by the dresser. On September 8, 2025, at 1:23 p.m., the surveyor observed at least five cardboard boxes, a clear plastic box, one duffle bag, and other items in the licensee's office located in the basement. On September 8, 2025, at 11:56 a.m., LALD-D stated they lived in the bedroom mentioned above. LALD-D stated they recently got laid off from another job and they were covering the night shift at the facility. LALD-D stated the items in the bedroom were their belongings. On September 8, 2025, at 1:22p.m., LALD-D stated the boxes found in the licensee's office were their belongings. LALD-D stated they brought their belongings to the licensee's facility since they recently got laid off. The surveyor asked if they had moved into the facility. LALD-D stated, no not moved in, but since they covered the night shift, they spend more time at the facility, so they brought their belongings. The surveyor asked from where they brought the belongings. LALD-D stated from where they were staying. The surveyor asked if LALD-D was now staying at the facility. LALD-D stated, "I spend more time here." The surveyor inquired to see LALD-D's identification card. LALD-D provided their driver's license issued in 2024, with a different address (not the licensee's facility address). The surveyor inquired to LALD-D if they	0 130			

Minnesota Department of Health

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0 130	Continued From page 6 were the current occupant of the address on the driver's license. LALD-D they were not the current occupant of the address provided on their driver's license. On September 10, 2025, at 12:25 p.m., R1 stated LALD-D worked the night shift. R1 stated they did not know if LALD-D slept at night when they were on duty. On September 10, 2025, at 2:44 p.m., LALD-D stated they were not allowed to sleep at night when they worked night shift, and stated they did not sleep when they worked. Minnesota Assisted Living Statutes 144G.08 definitions indicated: - Subd. 2. Adult - "Adult" means a natural person who has attained the age of eighteen years. - Subd. 5. Assisted living contract - "Assisted living contract" means the legal agreement between a resident and an assisted living facility for housing, and if applicable, assisted living services; - Subd. 7. Assisted living facility - "Assisted living facility" means a facility that provides sleeping accommodations and assisted living services to one or more adults. Refer to clauses 1-15 for exclusions. - Subd. 59. Resident. - "Resident" means an adult living in an assisted living facility who has executed an assisted living contract. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 130			

Minnesota Department of Health

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0 340	Continued From page 7	0 340			
0 340 SS=F	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or staff of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must: (1) document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have sufficient documentation with actions taken to comply with correction orders (tag identification: 0650, 0680, 0720, 810, 1500, 1530) for a survey completed on August 11, 2023. This had the potential to affect all residents, staff, and visitors at the facility. This practice resulted in a level two violation (a	0 340			

Minnesota Department of Health

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0 340	Continued From page 8 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 September 8, 2025, at 11:30 a.m., during the entrance conference licensed assisted living director (LALD)-D stated the licensee was familiar with current minimum assisted living requirements. On September 10, 2025, at approximately 11:45 a.m., LALD-D stated they did not have plan of correction to document the actions taken by the facility to comply with the correction orders. The correction orders for the survey completed on August 11, 2023, was electronically delivered to the licensee on September 13, 2023. The licensee lacked documentation to indicate correction orders previously cited on August 11, 2023, were in full compliance with assisted living statutes. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340			
0 420 SS=F	144G.40 Subdivision 1 Responsibility for housing and services The facility is directly responsible to the resident for all housing and service-related matters	0 420			

Minnesota Department of Health

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0 420	Continued From page 9 provided, irrespective of a management contract. Housing and service-related matters include but are not limited to the handling of complaints, the provision of notices, and the initiation of any adverse action against the resident involving housing or services provided by the facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide sufficient management, control, and operation of the housing and services provided by the facility. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee had an assisted living license, effective December 1, 2024. The licensee's (renewal) "Application for Assisted Living License", section titled "Official Verification of Owner or Authorized Agent", (page four and five of the application), identified an affirmative checkmark next to the statement, "I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659, governing the provision of assisted living facilities, and understand as the licensee I am legally	0 420			

Minnesota Department of Health

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0 420	Continued From page 10 responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract." Another checkmark was noted at the statement, "I have examined this application and all attachments, and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct and complete. I will notify MDH, in writing, of any changes to this information as required." Page six was electronically signed by the owner/authorized agent on November 1, 2024. As a result of this survey, the following orders were issued under 0130, 0340, 0460, 0480, 0650, 0660, 0680, 0720, 0730, 0790, 0800, 0810, 0910, 1290, 1320, 1440, 1500, 1530, 1620, 1790, and 1910, which indicated the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.01 to 144G.95. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 420			
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time;	0 460			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36732	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/10/2025
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0 460	Continued From page 11 (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 8, 2025, at 11:30 a.m., during the entrance conference, licensed assisted living director (LALD)-D stated there was no system in place for their resident to seek staff's assistance other than verbally calling out for help and staff were always there to answer. LALD-D stated, "It is almost one on one in a way".	0 460			

Minnesota Department of Health

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0 460	Continued From page 12 On September 8, 2025, at 11:55 a.m., during a facility tour, the surveyor observed a split-level home with no bells, call lights, pendants, or other means for the resident to seek staff's assistance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 460			
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (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	0 480			

Minnesota Department of Health

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0 480	Continued From page 13 operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. 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	0 480			

Minnesota Department of Health

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0 480	Continued From page 14 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated September 8, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 650 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; (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	0 650			

Minnesota Department of Health

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0 650	Continued From page 15 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 included all required content for two of two employees (unlicensed personnel (ULP)-A), clinical nurse supervisor (CNS)-C). 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: CNS-C CNS-C was hired on August 15, 2021, to provide oversight to the licensee's staff and to provide direct care services to the licensee's residents. CNS-C's employee record lacked annual performance review completed yearly, since hire. ULP-A ULP-A was hired on October 2, 2020, to provide direct cares and services to residents. ULP-A's employee record included Employee Performance Review Form dated November 29, 2023, for a review period of October 22, 2022, through November 30, 2023. ULP-A's record lacked annual performance review completed for	0 650			

Minnesota Department of Health

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0 650	Continued From page 16 year 2024. On September 9, 2025, at approximately 12:35 p.m., licensed assisted living director (LALD)-D stated they were unable to find any performance review for CNS-C and recent performance review completed for ULP-A. 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 and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for	0 660			

Minnesota Department of Health

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0 660	Continued From page 17 Disease Control and Prevention (CDC), which included a facility TB risk assessment, documentation of a completed health history and symptom screening, and completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for two of four employees (unlicensed personnel (ULP)-B, clinical nurse supervisor (CNS)-C). This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: The licensee's most recent Facility TB risk assessment worksheet for Health Care Settings licensed by MDH (Minnesota department of health) was completed on May 9, 2023. The licensee lacked a TB risk assessment completed in 2024 and 2025. ULP-B ULP-B was hired on November 15, 2025, to provide direct care services to residents. ULP-B's employee record lacked evidence a base line TB screening was completed upon hire or within 90 days prior to hire. CNS-C CNS-C was hired on August 15, 2021, to provide oversight to unlicensed personnel and to provide	0 660			

Minnesota Department of Health

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0 660	Continued From page 18 direct care to residents. CNS-C's employee record contained a Baseline TB Screening Tool for Health Care Workers (HCW's) form completed on August 15, 2023. The form contained symptoms of active TB disease assessment, assessment of HCW's TB history, and a negative TST result for a first step TST administered on October 30, 2023, and read on November 1, 2023. The HCW's form lacked second step TST which was supposed to be completed in one to three weeks per the direction on the HCW's form. On September 8, 2025, at 1:45 p.m., licensed assisted living director (LALD)-D stated they were unable to find a Tb risk assessment completed for the last two years therefore, they did not have it. On September 9, 2025, at 12:31 p.m., LALD-D stated they thought ULP-B had TB record on file, but it was not on file. LALD-D stated they would keep looking and they would contact ULP-B as well. On September 9, 2025, at 1:31 p.m., LALD-D stated they could not find ULP-B's TB record and ULP-B was also unable to produce TB result. LALD-D stated ULP-B would go get the TB screening done the next day. LALD-D stated they were responsible for keeping track of TB records and they did not know how they missed ULP-B's TB. On September 10, 2025, at 1:45 p.m., CNS-C stated they had not done any TB risk assessment for the licensee's facility. CNS-C stated they did not do any TB screening for employees; employees were supposed to get it done outside	0 660			

Minnesota Department of Health

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0 660	Continued From page 19 of the licensee. CNS-C stated employees needed to produce a negative TB result upon hire. CNS-C stated employees did not need to get a second TST done if the result for the first TST was negative. CNS-C stated if the result of the first step TST was positive then employees needed to get the second step TST done. CNS-C stated their first step TST was negative and that was why they did not do the second step TST. Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, indicated baseline TB screening is required for all health care workers. Baseline TB screening consists of three components: 1. Assessing for current symptoms of active TB disease, 2. Assessing TB history, and 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single TB blood test (IGRA). An employee may begin working with patients after a negative TB symptom screen (i.e., no symptoms of active TB disease) and a negative IGRA or TST (i.e., first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients. The licensee's undated Tuberculosis Screening Policy read, "The health screening will be completed by a licensed professional before client contact. Health screening will occur after a conditional offer of employment is made. Repeat testing will be required if deemed necessary by the health care professional for individuals with signs of communicable disease. The nurse manager will be responsible for assuring testing is completed and for any necessary follow-up.	0 660			

Minnesota Department of Health

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0 660	Continued From page 20 This will include any necessary training of supervisors and employees. For all employees or contract personnel providing direct client care, there shall be evidence of baseline TB screening consisting of two components: a. Assessing for current symptoms of active TB disease, (see Baseline TB Screening Tool in Sample Forms) and b. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step tuberculin skin test (TST) or a single TB blood test. If the employee has had a TB blood test or negative Chest X-ray within 90 days of employment, it does not have to be repeated at the time of hire. c. Employee history of BCG vaccination should be disregarded when administering and interpreting TST results 3. Tuberculin Skin Test (TST) TST is an intradermal injection of 0.1 ml of tuberculin (PPD) on the inner surface of the forearm. The test is an intradermal injection and should produce a pale elevation of the skin (a wheal) 6 - 10 mm in diameter. The skin test reaction should be read between 48-72 hours after administration. If the test is not read within 72 hours, another TST should be placed unless the amount of induration is 10mm or greater within 7 days. b. The reaction should be measured in millimeters of induration (palpable, raised, hardened area or swelling). Do not measure erythema (redness). The indurated area should be measured across the forearm (perpendicular to the long axis.) Health care workers, clients, or their family members may not record their own results.	0 660			

Minnesota Department of Health

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0 660	Continued From page 21 c. Determination for a positive TST result depends on the individual's risk factors for TB exposure or for developing active TB disease if infected. d. People who have been vaccinated with BCG should not be exempted from TB skin testing unless they have a documented positive result from a prior test. e. Employees with positive TST results must receive appropriate medical follow-up. 4. Two step testing a. A two step TST is required for baseline TB screening of health care workers who have not had a TST (Mantoux) within the previous three (3) months. If employee received Mantoux within 3 months of employment, that will be considered Step 1. Step 2 placed at time of hire. b. A two step Mantoux is performed at baseline because people who were infected with TB many years ago may have a negative reaction to an initial TST. The first "step" may stimulate the immune system's ability to react to the test. If the second "step" is not performed as part of baseline screening, a subsequent positive reaction could be misinterpreted as a new infection. If the first test is positive, second step is not given and employee would be referred for chest x-ray. c. If the first test is negative and the second step is positive, that indicates a boosted response and no further testing is necessary. (see attached Two Step Testing guidelines.) d. Treatment is encouraged for all health care personnel with untreated L TBI (latent TB infection), unless medically contraindicated." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 660			

Minnesota Department of Health

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0 660	Continued From page 22 (21) days	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 observation, interview, and record review the licensee failed to have a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This practice resulted in a level two violation (a	0 680			

Minnesota Department of Health

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0 680	Continued From page 23 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 8, 2025, at 11:55 a.m., during a facility tour, the surveyor observed the licensee lacked an EPP posted prominently. On September 9, 2025, at 12:35 p.m., licensed assisted living director (LALD)-D provided a white binder containing a generic template for an emergency preparedness plan (EPP). The licensee's EPP plan lacked customization to the facility and resident-specific individualization. The licensee's EPP binder, dated September 2022, lacked a documented annual review date and individualized emergency procedures to include the following: -written emergency disaster plan that contained a plan for evacuation, and detailed staff assignment in the event of a disaster or an emergency; -provided emergency exit diagrams to all residents; -transfer agreements and/or contracts with other facilities/providers to receive residents in the event of evacuation or other limitations that would impact the continuity of services; -handling and use of volunteers; -procedures for sharing medical information to maintain continuity of care; and procedures for sharing the emergency plan with family members and residents; -EPP testing requirements including an annual	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36732	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/10/2025
NAME OF PROVIDER OR SUPPLIER AMRAN HOME HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3228 COLUMBUS AVENUE SOUTH MINNEAPOLIS, MN 55407		
(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
0 680	Continued From page 24 full-scale exercise or individual facility-based functional exercise; and - review of missing resident plan. On September 9, 2025, at 2:35 p.m., LALD-D stated the licensee's emergency preparedness plan had been customized and stated, " I know we created it, hold on one second". The surveyor observed LALD-D go back in their office. On September 9, 2025, at 2:47 p.m., LALD-D stated they found the customized copy of the EPP saved on their computer and stated they would print it and make it available. On September 10, 2025, at 3:09 p.m., LALD-D stated they had the EPP saved on their computer, but they had not printed it. On September 10, 2025, at 1:39 p.m., clinical nurse supervisor (CNS)-C stated they reviewed the missing resident plan every three months or as needed. On September 10, 2025, at 1:41 p.m., LALD-D stated they reviewed the missing resident plan quarterly, "We do it verbally and if there is an incident I write it down". LALD-D also stated they reviewed the EPP every six months and stated they used paper documentation for the review; however, LALD-D was unable to provide the documentation for both EPP and missing resident plan review. On September 10, 2025, at 3:09 p.m., the surveyor requested LALD-D provide a copy of the EPP. LALD-D stated they had it on the computer, but they were unable to print the customized copy. LALD-D then confirmed that there was no EPP available for residents, staff, or volunteers to	0 680			

Minnesota Department of Health

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0 680	Continued From page 25 refer to in case of any emergency. The licensee's undated non-customized 2.01 Policies and Procedures Overview indicated the licensee shall maintain an Emergency Plan describing our all-hazards approach to emergency management. The Emergency Plan guidelines will be developed and made widely available to all staff. This plan will be maintained in accordance to state and federal guidelines will be reviewed and updated annually. The Emergency Plan is Incident Command System (ICS) compliant. The licensee's undated non-customized 2.28 Missing Resident plan indicated the licensee will review the policy and any individual resident plans that pertain to elopement at least quarterly, and all changes will be documented. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 720 SS=F	144G.43 Subd. 2 Access to records The facility must ensure that the appropriate records are readily available to employees and contractors authorized to access the records. Resident records must be maintained in a manner that allows for timely access, printing, or transmission of the records. The records must be made readily available to the commissioner upon request. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee	0 720			

Minnesota Department of Health

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0 720	Continued From page 26 failed to ensure records were readily available to employees authorized to have access, including maintaining records in a manner allowing for timely access of the records for a survey. This had the potential to affect all residents and facility staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or 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). Emergency Preparedness Plan On September 9, 2025, at 12:35 p.m., licensed assisted living director (LALD)-D provided a white binder containing a generic template for an emergency preparedness plan (EPP). On September 9, 2025, at 2:47 p.m., LALD-D stated they found the customized copy of EPP saved on their computer and stated they would print it and make it available. On September 10, 2025, at 3:09 p.m., LALD-D stated they had the EPP saved on their computer, but they had not printed it. ULP-E Employee Document On September 10, 2025, at 11:47 a.m., the surveyor requested documentation showing orientation and annual training had been completed for ULP-E. LALD-D stated, " I do not have [ULP-E's] documents, I saw it yesterday and I do not see it now, I do not know if it is my eye or what".	0 720			

Minnesota Department of Health

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0 720	Continued From page 27 No further information was provided. TIME PERIOD FOR CORRECTIONS: Seven (7) days	0 720			
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the	0 730			

Minnesota Department of Health

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0 730	Continued From page 28 needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a discharge summary with required content for one of one resident (R2) discharged from the licensee. 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: The licensee's undated Discharge or Deceased Resident Roster indicated R2 was admitted to the licensee on May 12, 2022, and discharged from the licensee on December 12, 2023.	0 730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36732	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/10/2025
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0 730	Continued From page 29 R2's diagnosis included high blood pressure, diabetes, and high cholesterol. R2's signed service plan dated May 1, 2022, indicated R2 received assistance with bathing (set up), dressing, meals, oral hygiene, hair care, grooming, medication administration, and safety check. On September 8, 2025, at 2:16 p.m., licensed assisted living director (LALD)-D stated R2 was not discharged formally, R2 went out of the country in December of 2023, and never returned. Email correspondence between the LALD and R2's case worker contained the following conversation: - September 10, 2024, at 3:15 p.m., R2's caseworker inquired if R2 still resided at the licensee. - September 18, 2024, at 9:52 a.m., LALD-D replied to the above inquiry, "No, he does not. He said he is going to visit his family and has not returned." On September 10, 2025, clinical nurse supervisor (CNS)-C stated they were told by the LALD that R2 was going out of the country and if R2 was to return they would return to the licensee. CNS-C stated they were supposed to do the formal discharge for R2, but they did not know if R2 was coming back or not. On September 10, 2024, at 2:27 p.m., LALD-D stated R2 was not paying rent and the last time R2 paid rent was November of 2023. R2's record lacked a Discharge-Transfer Summary report with the following required	0 730			

Minnesota Department of Health

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0 730	Continued From page 30 information: -a summary of the resident's stay that included courses of illnesses, treatments and therapies, and pertinent lab, radiology, and consultation results; -a final summary of the resident's status from the latest assessment or review under Minnesota Statutes, section 144G.70, if applicable, that includes the resident status, including baseline and current mental, behavioral, and functional status; -a reconciliation of all predischage medications with the resident's post discharge prescribed and over-the-counter medications; and -a post discharge plan that is developed with the resident and, with the resident's consent, the resident's representatives, which will help the resident adjust to a new living environment. The post discharge plan must indicate where the resident plans to reside, any arrangements that have been made for the resident's follow-up care, and any post discharge medical and nonmedical services the resident will need. The Licensee's 2.38 Resident Record-Information and Content policy dated August 1, 2021, indicated resident records must include a discharge summary, including service termination notice and related documentation, when applicable. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730			
0 790 SS=F	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment	0 790			

Minnesota Department of Health

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0 790	Continued From page 31 (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. 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, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 10, 2025, from 11:30 a.m. to 1:30 p.m., the surveyor toured the facility with licensed assisted living director (LALD)-D. The portable fire extinguishers throughout the facility lacked records to show the required annual certification was completed and lacked records to show monthly visual inspections were complete.	0 790			

Minnesota Department of Health

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0 790	Continued From page 32 Documentation is required to demonstrate fire extinguishers have been inspected by facility personnel monthly, and annually replaced with a new extinguisher or serviced annually by a certified technician. These deficient conditions were visually verified at the time of discovery by LALD-D accompanying on the tour. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790			
0 800 SS=D	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, in a continuous state of good repair and operation. This had the potential to directly affect some residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 800			

Minnesota Department of Health

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0 800	Continued From page 33 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On September 10, 2025, from 11:30 a.m. to 1:30 p.m., the surveyor toured the facility with licensed assisted living director (LALD)-D. The following was observed. The egress window in basement bedroom E had hardware that was not maintained in proper working condition and obstructed the window from opening completely. Egress windows must be maintained in proper working order to ensure safe egress during the event of a fire or similar emergency. This deficient condition was visually verified at the time of discovery by LALD-D accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800			
0 810 SS=I	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;	0 810			

Minnesota Department of Health

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0 810	Continued From page 34 (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. 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 three violation (a violation that harmed a resident's health or safety,	0 810			

Minnesota Department of Health

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0 810	Continued From page 35 or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 10, 2025, licensed assisted living director (LALD)-D provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. The fire safety and evacuation plan was not located in a central location for all staff accessibility. LALD-D spent a significant amount of time searching for the policy in their office. LALD-D stated the policy was on their computer and spent 10 additional minutes searching for it on the computer. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, 9.06 Fire Policy, dated August 1, 2021, failed to include the following: The FSEP lacked any plans or diagrams showing the location and number of resident sleeping rooms. 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	0 810			

Minnesota Department of Health

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0 810	Continued From page 36 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 staff for assisting residents during evacuation, nor did it include instructions for staff to follow in case of relocation. On September 10, 2025, at 1:00 p.m. LALD-D stated they had an updated FSEP and would email it to the surveyor by 5:00 p.m. on September 10, 2025. The policy received was titled Fire Safety and Evacuation Plan, undated. The FSEP lacked any plans or diagrams showing the location and number of resident sleeping rooms. 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 failed to include procedures for how staff are to complete each	0 810			

Minnesota Department of Health

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0 810	Continued From page 37 step. The FSEP did not identify specific fire protection actions for residents. The section titled "Fire Protection Procedure necessary for Resident" did not include the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The licensee failed to develop and maintain their FSEP. The licensee provided multiple policies from multiple third-party provider groups for the surveyor to review. None of the policies reviewed met all the requirements for the FSEP listed in statute. Each policy had a different version of each requirement or lacked all required sections. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. LALD-D lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. The licensee's training records, indicated staff were trained on November 15, 2024. No other training documentation was provided. On September 10, 2025, at 1:30 p.m., LALD-D stated they complete training for employees at the same time they conduct evacuation drills and quarterly as a group. No documentation of quarterly training was provided. All staff are required to be trained on the FSEP, not only staff completing an evacuation drill.	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36732	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/10/2025
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0 810	Continued From page 38 DRILLS: The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. An evacuation drill schedule was posted on the main level by the basement door that indicated evacuation drills were scheduled to be completed monthly. LALD-D lacked documentation that any evacuation drills were completed. On September 10, 2025, at 1:30 p.m., LALD-D stated they could not find any evacuation drill documentation. TIME PERIOD FOR CORRECTION: Seven (7) days	0 810			
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for all residents who resided in the licensee's facility.	0 910			

Minnesota Department of Health

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0 910	Continued From page 39 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 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 September 9, 2025, at 8:59 a.m., licensed assisted living director (LALD)-D provided a blank contract titled Assisted Living Contract. The licensee's Assisted Living Contract lacked the following required content: - in a conspicuous place and manner on the contract the Health Facility Identification number (HFID#) of the facility. R1's Assisted Living Contract signed on December 1, 2023, lacked the following required content: - in a conspicuous place and manner on the contract the legal name and HFID# of the licensee. On September 10, 2025, at 2:38 p.m., LALD-D stated they were not aware of the requirement to include the HFID# in the assisted living contract. LALD-D stated the blank contract would be used for any future residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36732	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/10/2025
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01290	Continued From page 40	01290			
01290 SS=D	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study (BGS) was submitted and received in affiliation with the assisted living licensee for one of seven employees (unlicensed personnel (ULP)-A). This had the potential to affect all residents living in the assisted living facility. This resulted in an immediate correction order on September 8, 2025. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the	01290			

Minnesota Department of Health

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01290	Continued From page 41 situation has occurred only occasionally). The findings include: ULP-A was hired on October 2, 2020, to provide direct cares and services to residents. The licensee's NETStudy 2.0 (web-based system used to submit background study requests to the Department of Human Services (DHS)) roster printed on September 8, 2025, at 11:18 a.m., indicated ULP-A's eligible COVID-19 Study was expired on December 31, 2022. On September 8, 2025, at approximately 11:20 a.m., licensed assisted living director (LALD)-D stated ULP-A was an on-call staff member. On September 8, 2025, at 12:34 p.m., LALD-D stated ULP-A was on leave of absence for long time. LALD-D stated ULP-A was on-call and they could be called in to work at the licensee facility any time help was needed. LALD-D stated they noticed today ULP-A's COVID-19 eligibility status was expired. On September 8, 2025, at 12:38 p.m., LALD-D stated ULP-A last worked on August 20, 2025, after ULP-A got back from the leave of absence. The licensee's work schedule dated September 7, 2025, through September 13, 2025, did not include ULP-A. The licensee's policy dated August 1, 2021, read, "POLICY: [Name of AL] will conduct a Minnesota Department of Human Services Background Study on all employees and volunteers and contractors at [Name of AL]. No employee may provide direct services and	01290			

Minnesota Department of Health

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01290	Continued From page 42 have independent direct contact with any residents until acceptable result of the background study have been received. [Name of AL] will not employ individuals whose results of the background study indicate disqualification for the position." The DHS website for Background Studies updated August 7, 2025, indicated, "DHS temporarily modified background studies during the COVID-19 pandemic. Modifications ended Jan. 1, 2023, and emergency studies are no longer valid." On September 8, 2025, the Minnesota Department of Human Services website indicated the following: - Emergency studies completed during the COVID-19 pandemic were no longer valid. - Individuals who only had an emergency study must have a fully compliant, fingerprint-based background study. Roster maintenance - Individuals with a completed emergency study will remain on the entity's roster unless the entity removes the individual. Entities should remove individuals with emergency studies that are no longer affiliated; - If the individual should no longer be affiliated and has a new fully compliant background study, the entity should wait until the individual is separated and then remove both the emergency study and fully compliant study from their roster at the same time; - All entities are responsible for maintaining their rosters regularly and removing study subjects from their roster when they are no longer affiliated; and - Entities are responsible for identifying who needs to submit a new background study. For	01290			

Minnesota Department of Health

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01290	Continued From page 43 help identifying which study subjects still have an emergency study and need a fully compliant study, entities should refer to the instructional guide, "Identifying Emergency Studies" in the help section of NETStudy 2.0. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290			
01330 SS=F	144G.60 Subd. 4 (b) Unlicensed personnel (b) Unlicensed personnel performing delegated nursing tasks in an assisted living facility must: (1) have successfully completed training and demonstrated competency by successfully completing a written or oral test of the topics in section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform; (2) satisfy the current requirements of Medicare for training or competency of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or 484.36; or (3) have, before April 19, 1993, completed a training course for nursing assistants that was approved by the commissioner. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for one of one unlicensed personnel ((ULP)-B).	01330			

Minnesota Department of Health

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01330	Continued From page 44 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: ULP-B ULP-B was hired on November 15, 2024, to provide direct care services to the licensee's residents. On September 9, 2025, licensed assisted living director (LALD)-D stated ULP-B could administer medication to the licensee's residents. ULP-B's employee record contained the following training and competency evaluations: - bathing assistance; - dressing assistance; - hair care assistance; - hearing aide use and care; - nail care assistance; - oral care assistance; - assistance with eating; - basic nutrition/food safety; - clean and safe environment; - documenting observing and reporting; - personal care AL and HC; - siderails; and - fall risk and prevention. ULP-B's employee record lacked the following training and competency evaluations: - reports of changes in the resident's condition	01330			

Minnesota Department of Health

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01330	Continued From page 45 to the supervisor designated by the assisted living provider; - standby assistance techniques and how to perform them; - medication, exercise, and treatment reminders; - preparation of modified diets as ordered by a licensed health professional; - awareness of commonly used health technology equipment and assistive devices; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; - reading and recording temperature, pulse, and respirations of the resident; - recognizing physical, emotional, cognitive, and developmental needs of the resident; - safe transfer techniques and ambulation; and - range of motioning and positioning. On September 10, 2025, at 1:59 p.m., clinical nurse supervisor (CNS)-C stated they have not trained employees on the above-mentioned topics missing from ULP-B's employee record. CNS-C stated the licensee only had one resident and they trained the ULPs on exactly what the resident needs were. CNS-C stated, "resident is independent, so I have not trained them on standby and ambulation." Although requested the licensee did not provide a training policy. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01330			

Minnesota Department of Health

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01440	Continued From page 46	01440			
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for one of one employee (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01440			

Minnesota Department of Health

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01440	Continued From page 47 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: ULP-B was hired on November 15, 2024, to provide direct care services to the licensee's residents. On September 8, 2025, at 11:00 a.m., upon entering the facility the surveyor observed ULP-B communicating with R1. ULP-B's employee record contained 30-Day Staff Performance Review Sample Form dated December 15, 2024, which was reviewed and signed by licensed assisted living director (LALD)-D. The form addressed the following performance factors: - customer focus; - communication; - teamwork and attitude; - productivity; and - safety; and dependability. ULP-B's record lacked a 30-day supervision by the registered nurse to include observation of staff providing a delegated procedure and interaction with resident. On September 8, 2025, LALD-D stated ULP-B was the only full-time employee. ULP-B covered day shifts and performed all delegated nursing tasks during the day. On September 10, 2025, at 1:52 p.m., clinical nurse supervisor (CNS)-C stated they showed	01440			

Minnesota Department of Health

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01440	Continued From page 48 delegated tasks to ULPs upon hire and then they watched the ULPs return demonstrate the tasks. CNS-C stated, "the days that I am here I watch them and correct them if they need correction but for the most part it is simple." CNS-C stated they did not do formal 30-day supervision, and they did not have any documentation for that. The licensee's 6.17 Supervision of Staff-Delegated Services policy dated August 1, 2021, indicated direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the licensee and first performs the delegated tasks for residents and thereafter as needed based on performance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440			
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	01500			

Minnesota Department of Health

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01500	Continued From page 49 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. 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	01500			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36732	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/10/2025
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01500	Continued From page 50 access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received at least eight hours of annual training for each 12 months of employment for three of three employees (licensed assisted living director (LALD)-D, clinical nurse supervisor (CNS)-C, unlicensed personnel (ULP)-A). 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: CNS-C CNS-C was hired on August 15, 2021, to provide oversight to the licensee's staff and to provide direct care services to the licensee's residents. CNS-C's record contained training records last completed in September of 2023. LALD-D LALD-D was hired on February 14, 2019, to provide direct care services to the licensee's residents. LALD-D's record contained training and competency records completed in September of 2021. ULP-A ULP-A was hired on October 2, 2020, to provide	01500			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36732	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/10/2025
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01500	Continued From page 51 direct cares and services to residents. ULP-A's record contained training and competency records last completed in August of 2023. LALD-D, CNS-C, ULP-A's records lacked documentation of eight hours of annual training completed for every 12 months employment, including the following required topics: -reporting of maltreatment of vulnerable adults; - assisted Living bill of rights; - infection control; -effective approached to use to problem solve when working with a resident's challenging behaviors and how to communicate with residents who have dementia or related disorders; -review of provider's policies and procedures; and - principals of person-centered planning/service delivery. On September 9, 2025, at 10:05 a.m., the surveyor observed licensed assisted living director LALD-D perform medication administration to R1. The surveyor also observed ULP-A communicate with R1 during medication administration. On September 9, 2025, at 11:07 a.m., LALD-D stated ULP-A had to take a leave multiple times for a few weeks and few months at a time and that was why they did not complete the annual training. LALD-D stated they were now assigning Educare training (electronic training software) to make sure annual trainings were completed. LALD-D stated they were in the process of assigning Educare training to the rest of employees as well. Although requested the licensee did not provide a training policy.	01500			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36732	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/10/2025
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01500	Continued From page 52 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01500			
01530 SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness 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	01530			

Minnesota Department of Health

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01530	Continued From page 53 paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure four of four employees (licensed assisted living director (LALD)-D, clinical nurse supervisor (CNS)-C, unlicensed personnel (ULP)-A, ULP-B) received at least two hours of annual dementia care training, eight hours of initial dementia care training, and two hours of initial mental illness and de-escalation training within the required time frame. 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: ULP-A ULP-A was hired on October 2, 2020, to provide direct cares and services to residents. ULP-A's record included the following dementia training topics completed August 17, 2023:	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36732	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/10/2025
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01530	Continued From page 54 - person centered planning and service delivery; and - effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with resident who have dementia, Alzheimer's disease, or related disorders. ULP-A's record lacked two hours of annual dementia training completed in 2024, and 2025. CNS-C CNS-C was hired on August 15, 2021, to provide oversight to the licensee's staff and to provide direct care services to the licensee's residents. CNS-C's employee record included dementia training on the following topic completed on September 16, 2023: - person centered planning and service delivery: Alzheimer's disease and related disorders. CNS-C's records lacked documentation they completed at least two hours of initial mental illness and de-escalation training and two hours of dementia training and eight hours of initial dementia care training on the following required topics within 120 working hours, including: - an explanation of Alzheimer's disease and other dementia; - assistance with activities of daily living; - problem solving with challenging behaviors; and - communication skills. LALD-D LALD-D was hired on February 14, 2019, to provide an oversight to the licensee's staff and to provide direct care services to the licensee's residents.	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36732	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/10/2025
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01530	Continued From page 55 LALD-D's records lacked documentation they completed at least two hours of initial mental illness and de-escalation training, two hours of annual dementia care training, and eight hours of initial dementia care training on required topics within 120 working hours, including: - an explanation of Alzheimer's disease and other dementia; - assistance with activities of daily living; - problem solving with challenging behaviors; - communication skills; and - person-centered planning and service delivery. ULP-B ULP-B was hired on November 15, 2024, to provide direct care services to the licensee's residents. ULP-B's records record included 2.5 hours of mental illness and de-escalation training completed on September 8, 2025, during the survey. ULP-B's record lacked documentation they completed eight hours of initial dementia care training on required topics within 160 working hours, including: - an explanation of Alzheimer's disease and other dementia; - assistance with activities of daily living; - problem solving with challenging behaviors; - communication skills; and - person-centered planning and service delivery. On September 9, 2025, at 2:01 p.m., CNS-C stated they were not aware of the required dementia training for assisted living. CNS-C inquired, "Is dementia training even required? If you do not have dementia client. I am not aware of the dementia training for assisted living. I did not see that it was requirement."	01530			

Minnesota Department of Health

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01530	Continued From page 56 On September 9, 2025, at 2:26 p.m., licensed assisted living director (LALD)-D stated they did not realize the above-mentioned employees were missing the required dementia and mental illness training. LALD-D stated CNS-C and ULP-B had worked more than 120 hours and 160 hours respectively. Although requested the licensee did not provide a dementia training policy. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) 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 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:	01620			

Minnesota Department of Health

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01620	Continued From page 57 (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident assessment and reassessment, not to exceed 90 calendar days from the last date of the assessment for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01620			

Minnesota Department of Health

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01620	Continued From page 58 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 was admitted to the licensee on October 1, 2020, with diagnoses that included schizophrenia. R1's unsigned Service Plan with effective date of July 4, 2025, indicated R1 received services for bathing, dressing, grooming, incontinence care, medication administration, and meal assistance, and home safety check. R1's record included 90-day nursing assessments dated September 4, 2023, March 11, 2024, June 30, 2024, October 12, 2024, January 15, 2025, and March 13, 2025. The assessment completed on March 11, 2024, was late by 99 days, the assessment completed on June 30, 2024, was late by 21 days, the assessment completed on October 12, 2024, was late by 14 days, the assessment completed on January 15, 2025, was late by 5 days. The most recent assessment for R1 was completed on March 15, 2025, R1's record lacked 90-day assessment which were due on June 11, 2025, and September 9, 2025. On September 11, 2025, at 12:21 p.m., clinical nurse supervisor (CNS)-C stated assessments were supposed to be completed every 90 days or when there is change in a resident's condition. CNS-C stated they had a baby last year in June and they also had another baby recently, a few	01620			

Minnesota Department of Health

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01620	Continued From page 59 days ago, and they did not get the chance to complete the assessments on time. The licensee's 6.01 Nursing Assessments Reviews and Monitoring policy, dated August 1, 2021, indicated resident review and monitoring must be conducted as needed based on changes in the needs of the residents and cannot exceed 90 calendar days from the date of the last review. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for	01790			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36732	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/10/2025
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01790	Continued From page 60 giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the	01790			

Minnesota Department of Health

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01790	Continued From page 61 licensee failed to ensure the registered nurse (RN) developed training and competencies for unlicensed personnel (ULP) providing medications to residents for unplanned time away from home when the licensed nurse was not available for three of three employee (unlicensed personnel (ULP)-A, ULP-B) and licensed assisted living director (LALD)-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: LALD-D LALD-D was hired on February 14, 2019, to provide direct care services to the licensee's residents. ULP-A ULP-A was hired on October 2, 2020, to provide direct cares and services to residents. ULP-B ULP-B was hired on November 15, 2024, to provide direct care services to the licensee's residents. LALD-D, ULP-A, and ULP-B's employee record lacked documentation of training and a competency evaluation for unplanned time away from home medication administration.	01790			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36732	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/10/2025
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01790	Continued From page 62 On September 10, 2025, at 2:48 p.m., clinical nurse supervisor (CNS)-C stated they did not have an unplanned time away medication administration system in place as the resident hardly leaves the facility. CNS-C stated they had not trained any of the employees on how to prepare medication for when the resident takes unplanned leave. The licensee's Medication Management Plan for Clients Away from Home policy dated October 31st, 2023, read "2. For unplanned times away from home for temporary periods when an adequate medication supply cannot be obtained from the pharmacy or set up by the Registered Nurse in a timely manner, the Registered Nurse may delegate an unlicensed personnel (home health aide) to set up the medications based on the following a. The home health aide has documentation of passing a competency evaluation for medication administration b. The Registered Nurse has instructed the home health aide to ensure that all appropriate precautions are taken c. The home health aide may set up not more than a 72-hour supply of the client's medications" No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01790			
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer	01910			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36732	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/10/2025
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01910	Continued From page 63 part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation of disposition of medications for one of one discharged resident (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: The licensee's undated Discharge or Deceased Resident Roster indicated R2 was admitted to the licensee on May 12, 2022, and discharged from	01910			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36732	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/10/2025
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01910	Continued From page 64 the licensee on December 12, 2023. R2's diagnosis included high blood pressure, diabetes, and high cholesterol. R2's signed service plan dated May 1, 2022, indicated R2 received assistance with bathing (set up), dressing, meals, oral hygiene, hair care, grooming, medication administration, and safety check. R2's record lacked evidence of documented disposition of medications for R2 to include: the name of the medication, strength, prescription number if applicable, quantity, to whom the medications were given, date of disposition, and the names of the staff and other individuals involved in the disposition. On September 10, 2025, at 2:56 p.m., clinical nurse supervisor (CNS)-C stated R2 was taking medication during their stay, and they took their medications with them when they left. CNS-C stated they did not physically hand the medications to R2, and they did not do medication disposition documentation for R2's medications. On September 10, 2025, at 2:57 p.m., licensed assisted living director (LALD)-D stated R2 took a 90 day medication supply with them when they left. LALD-D stated they trained R2 and R2's son on how to take the medications and gave it to them. On September 10, 2025, at 3:05 p.m., LALD-D stated they did not have the medication disposition form and stated, "it is going to take a minute to find it".	01910			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36732	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/10/2025
NAME OF PROVIDER OR SUPPLIER AMRAN HOME HEALTH CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3228 COLUMBUS AVENUE SOUTH MINNEAPOLIS, MN 55407			
(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
01910	Continued From page 65 On September 11, 2025, at 8:48 a.m., LALD-D stated they did not find a medication disposition form for R2. The licensee's Disposition/Disposal of Medications policy dated October 31, 2023, indicated upon disposition of medication the licensee will document the following information in the clinical record: - Name, strength and prescription number of medication as applicable; - Quantity; - Method of disposition or to whom the medication where given; - Date of disposition; and - Name (s) and signature(s) of staff involved in disposition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910			



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

AMRAN HOME HEALTH CARE LLC
3228 COLUMBUS AVENUE SOUTH
Minneapolis, MN 55407
Hennepin County
Parcel:

Phone:

License Info

License: HFID 36732

Risk:
License:
Expires on:
CFPM: Nimo Yusuf
CFPM #: 111072; Exp: 03/04/2025

Inspection Info

Report Number: F1013251080
Inspection Type: Full - Single
Date: 9/8/2025 Time: 1:30 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 1
Total Priority 2 Orders: 3
Total Priority 3 Orders: 1
Delivery:

New Order: 2-100 Supervision

2-102.12AMN *Priority Level: Priority 3 CFP#: 2*

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

COMMENT: THE OPERATOR'S MN CFPM EXPIRED ON 3/4/25. THEY COMPLETED CONTINUING EDUCATION BEFORE THE EXPIRATION DATE. COMPLY WITH RULE. THE MN CFPM RENEWAL INFORMATION WAS PROVIDED.

Comply By: 10/1/2025 Originally Issued On: 9/8/2025

New Order: 4-300 Equipment Numbers and Capacities

4-301.12A *Priority Level: Priority 2 CFP#: 48*

MN Rule 4626.0680A Provide a 3 compartment sink with integrally attached drainboards at each end for manually washing, rinsing and sanitizing equipment and utensils.

COMMENT: NO WARE WASHING EQUIPMENT IS AVAILABLE IN THE KITCHEN. COMPLY WITH RULE. A 3-COMPARTMENT SINK OR DISH WASHING MACHINE MUST BE INSTALLED. PROVIDE INSPECTOR WITH A PLAN TO INSTALL WARE WASHING EQUIPMENT.

Comply By: 9/12/2025 Originally Issued On: 9/8/2025

New Order: 4-300 Equipment Numbers and Capacities

4-302.12B *Priority Level: Priority 2 CFP#: 36*

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

COMMENT: THE FACILITY COOKS THIN MEATS (FISH, LAMB). NO FOOD PROBE THERMOMETER WAS AVAILABLE. COMPLY WITH RULE. DISCUSSED THERMOMETER USE WITH STAFF.

Comply By: 9/12/2025 Originally Issued On: 9/8/2025

New Order: 4-300 Equipment Numbers and Capacities

4-302.14 *Priority Level: Priority 2 CFP#: 48*

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

COMMENT: CHLORINE SANITIZER WILL BE USED IN THE KITCHEN. COMPLY WITH ABOVE RULE. DISCUSSED SANITIZER TEST KIT USE WITH STAFF.

Comply By: 9/12/2025 Originally Issued On: 9/8/2025

! New Order: 4-700 Sanitizing Equipment and Utensils

4-702.11 *Priority Level: Priority 1 CFP#: 16*

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

COMMENT: STAFF WASHED WARE WITH ONLY SOAP AND WATER. NO DISH MACHINE OR 3-COMPARTMENT SINK WERE AVAILABLE. COMPLY WITH RULE. DISCUSSED WARE WASHING PROCEDURES WITH STAFF. A LARGE CONTAINER WITH SANITIZER MAY BE USED TO SANITIZE WARE BEFORE AIR DRYING UNTIL PERMANENT WARE WASHING EQUIPMENT IS INSTALLED.

Comply By: 9/8/2025 Originally Issued On: 9/8/2025

Food & Beverage General Comment

The inspection was completed with the operator then reviewed with MDH Nurse Evaluator D. Mosissa.

The establishment has a residential kitchen and serves food prepared that day. The kitchen has wood cabinets, vinyl floor, painted walls, laminate counter top, and a smooth painted ceiling.

A two basin sink is located in the kitchen. One basin is designated for hand washing.

No dish machine or 3-compartment sink were available for ware washing.

Discussed hand washing, ware washing, staff illness policy, temperature control, final cook temperatures, cleaning, serving highly susceptible populations, food storage, and food handling procedures.

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 F1013251080 from 9/8/2025

Jerry Malloy

Nimo Yusuf
Operator

Jerry Malloy,
Public Health Sanitarian Supervisor
651-201-3998
jerry.malloy@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

AMRAN HOME HEALTH CARE LLC
Minneapolis
County/Group: Hennepin County

Inspection Info

Report Number: F1013251080
Inspection Type: Full
Date: 9/8/2025
Time: 1:30 PM

Food Temperature: **Product/Item/Unit:** Milk; **Temperature Process:** Cold-Holding

Location: Refrigerator at 41 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** Corn; **Temperature Process:** Cold-Holding

Location: Refrigerator at 41 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** Salmon; **Temperature Process:** Cold-Holding

Location: Freezer at 28 Degrees F.

Comment:

Violation Issued?: No