



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF INITIAL LICENSE DENIAL

Electronically Delivered
September 28, 2026

Licensee
Assisted Co LLC
223 Winifred Street
Saint Paul, MN 55107

RE: Denial of License Number 420730
Health Facility Identification Number (HFID) 41079
Initial survey; Project Number(s) SL41079001

Dear Licensee:

The Minnesota Department of Health (MDH) completed an initial survey on June 24, 2026 for the purpose of assessing compliance with state licensing statutes and determine issuance of an initial license to the above-mentioned provider. Based on the survey(s), MDH found you not in substantial compliance with the laws pursuant to Minnesota Statute, Chapter 144G. As a result, your authority to continue to operate under a provisional license or be approved for an assisted living facility license is being denied.

INELIGIBLE LICENSURE TIMELINE

Pursuant to Minn. Stat. § 144G.16, subd. 3 (c), the owners and managerial officials of a provisional licensee whose license is denied are ineligible to apply for an assisted living facility license under this chapter for one (1) year following the facility's closure date.

STATE CORRECTION ORDERS

The enclosed State Form documents the state licensing orders. The Department of Health documents state 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 . . ."

REQUEST FOR RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.16, Subd. 4, you may request a reconsideration by the Minnesota Department of Health. The request for reconsideration process must be conducted internally by the Minnesota Department of Health and Chapter 14 does not apply. **This is your only ability to request a reconsideration under this enforcement action.**

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

Note requests for reconsideration must be received by the department within 15 calendar days of the date of this notice.

REQUIREMENTS FOR NOTIFICATION AND TRANSFER OF RESIDENTS

You must comply with the requirements for notification and coordinated move of residents noted in Minn. Stat. § 144G.52 and Minn. Stat. § 144G.55. Additionally, please provide the information described in Minn. Stat. § 144G.20, Subd. 15 (a) (1), (2), (3), (4) and (5) to this department's contact, Renee Anderson, via email at: Renee.L.Anderson@state.mn.us. Also provide this information to the lead agencies as defined in section 256B.0911, county adult protection and case managers, and the ombudsman for long-term care no later than **Thursday, October 1, 2026**.

Pursuant to Minn. Stat. § 144G.16, Subd. 5 (3), a provisional licensee whose license is denied is permitted to continue operating as an assisted living facility during the period of time when a transfer of assisted living facility resident(s) from the provisional licensee to a new assisted living facility provider is in process.

Additionally, pursuant to Minn. Stat. § 144G.16, Subd. 5 (1), you may continue operating during the reconsideration process.

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

If you have any additional questions, please do not hesitate to contact Renee Anderson, Supervisor, at Renee.L.Anderson@state.mn.us. Renee Anderson can also be reached by office phone at 651-201-5871.

Sincerely,



Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41079	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/24/2026
NAME OF PROVIDER OR SUPPLIER ASSISTED CO LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 223 WINIFRED STREET SAINT PAUL, MN 55107		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL #41079001-0 On June 22, 2026, through June 24, 2026, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 3 residents, all of whom were receiving services under the provider's provisional Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level pursuant to 144G.31 Subd. 1, 2 and 3.		
0 480 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	0 480			

Minnesota Department of Health

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

TITLE

(X6) DATE

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0 480	Continued From page 1 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part	0 480			

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0 480	Continued From page 2 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 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated June 22, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			

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0 550	Continued From page 3	0 550			
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post in a conspicuous place, the required information related to its grievance procedure, with all required content. This had the potential to affect all residents, staff, and visitors to the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 550			

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0 550	Continued From page 4 The findings include: The licensee lacked a posting to include all the required content about the facility's grievance procedure to include the name, telephone number and email contact information for the individuals who are responsible for handling grievances. On June 22, 2026, at 10:45 a.m., during a tour of the licensee's facility, the surveyor observed the licensee information board in the main living room area with manager/unlicensed personnel (M/ULP)-A. The board lacked information about the licensee's grievance procedure. M/ULP-A stated they had the information located in a binder but did not know they also needed to have it posted. The licensee's undated Complaint and Investigation Process policy indicated residents of the facility would be "provided with written information about how to address their concerns and questions related to their care." The policy lacked an indication the information would be posted in a conspicuous place. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550			
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and	0 640			

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0 640	Continued From page 5 suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment as required. This had the potential to affect all the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 June 22, 2026, at 10:45 a.m., during a tour of the licensee's facility, the surveyor observed the licensee information board in the main living room area with manager/unlicensed personnel (M/ULP)-A. The board lacked a posting with information for reporting suspected maltreatment to the MAARC. MULP-A stated they had the	0 640			

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0 640	Continued From page 6 information located in a binder and had not known they also needed to have it posted. The licensee's undated Reporting Maltreatment of Vulnerable Adult policy indicated that the licensee would have information and the reporting number for the MAARC posted in the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640			
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 observation, interview, and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by	0 660			

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0 660	Continued From page 7 the Centers for Disease Control and Prevention (CDC) which included baseline TB screening by completion of a two-step tuberculin skin test (TST), TB blood test, or documented history of positive TB test with the required follow up chest x-ray for two of two employees (manager/unlicensed personnel (M/ULP)-A, 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 cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's undated Facility TB Risk Assessment indicated the facility was at a low risk for TB transmission. M/ULP-A and ULP-B were hired May 8, 2025, and June 18, 2025, respectively to provide direct care for residents of the facility. On June 22, 2026, at 12:20 p.m., the surveyor observed M/ULP-A assist R2 with medication administration. On June 22, 2026, at 1:24 p.m., the surveyor observed the licensee's undated weekly staff schedule. The schedule indicated M/ULP-A and ULP-B each worked 12-hour shifts Monday through Friday. M/ULP-A stated the schedule was consistent week to week.	0 660			

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0 660	Continued From page 8 M/ULP-A's record included a letter from Ramsey County Public Health, indicating M/ULP-A was "not infectious and can attend work or school with no restrictions." The record lacked documentation of a two-step tuberculin skin test (TST), TB blood test, or documented history of positive TB test with the required follow up chest x-ray. ULP-B's record included a letter indicating ULP-B had been evaluated for TB and their "chest x-ray is not concerning for active TB." The record lacked documentation of either a previous positive TB test or documentation of completion of TB treatment, correlated to the chest x-ray. On June 23, 2026, at 2:00 p.m., RN-C stated they had completed the facility TB risk assessment when they started working for the licensee in April 2026. RN-C further stated they had not realized there needed to be documentation of a previous positive TB test included with a chest x-ray and the licensee would need to change their process. The licensee's undated Tuberculosis Screening policy indicated baseline screening for TB would include either a two-step TST or a single TB blood test. If the employee had proof of a TB blood test or negative chest x-ray within 90 days of employment, it would not have to be repeated at the time of hire. The policy lacked an indication that a documented history of a positive TB test was required with a follow up chest x-ray. The CDC's Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel: Recommendations from the National Tuberculosis Controllers Association and CDC dated May 17, 2019, recommended all health care professionals complete a TB screening including a symptom evaluation and an IGRA or	0 660			

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0 660	Continued From page 9 TST. Health care workers with written documentation of a previous positive TST or IGRA should have documented in their record: test results, assessment for current TB symptoms and a related chest x-ray. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (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.	0 680			

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0 680	Continued From page 10 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness (EP) plan with all required content as defined in Centers for Medicare and Medicaid Services (CMS) Appendix Z. 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 the potential to affect a large portion or all of the residents). The findings include: The licensee's undated EP plan lacked evidence it was reviewed annually, and lacked the following required content: - post an emergency disaster plan prominently; - facility hazard risk assessment - 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; - documentation of two emergency preparedness exercises (an annual full-scale exercise or individual facility-based functional exercise and a second full-scale exercise that was either community-based, an individual facility based functional exercise, a mock disaster drill, or a table-top exercise. On June 24, 2026, at 9:00 a.m.,	0 680			

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0 680	Continued From page 11 manager/unlicensed personnel (M/ULP)-A stated they did not know they needed to post the EP plan and they did not have documentation of any disaster drills. M/ULP-A further stated he was not sure if the hazard risk assessment had been completed by owner (O)-D. The licensee's Emergency Preparedness policy, dated May 1, 2025, indicated the licensee would conduct a disaster drill at least annually. Minnesota Administrative Rule 4659.0100 dated August 11, 2021, indicated assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.72, or successor requirements. This part referenced documents, specifications, methods, and standards in State Operations Manual Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types: Interpretive Guidance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical	0 775			

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0 775	Continued From page 12 environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated June 23, 2026, for specific violations related to the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Two (2) days	0 775			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.	0 800			

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0 800	Continued From page 13 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated June 23, 2026, for specific violations related to the physical environment under Minnesota Statute 144G. 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; (2) staff actions to be taken in the event of a fire or similar emergency;	0 810			

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0 810	Continued From page 14 (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 ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a widespread scope (when problems	0 810			

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0 810	Continued From page 15 are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated June 23, 2026, for specific violations related to the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
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	01440			

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01440	Continued From page 16 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 observation, 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 two of two employees (manager/unlicensed personnel (M/ULP)-A, 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 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: M/ULP-A and ULP-B were hired May 8, 2025, and June 18, 2025, respectively to provide direct care for residents of the facility. On June 22, 2026, at 12:20 p.m., the surveyor observed M/ULP-A assist R2 with medication administration. M/ULP-A stated they had in-person training with the RN on medication administration. On June 22, 2026, at 1:24 p.m., the surveyor observed the licensee's undated weekly staff schedule. The schedule indicated M/ULP-A and ULP-B each worked 12-hour shifts Monday through Friday. M/ULP-A stated the schedule was	01440			

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01440	Continued From page 17 consistent week to week. M/ULP-A and ULP-B's records lacked evidence of RN supervision of a delegated task within 30 days of performing the delegated task. On June 23, 2026, at 12:15 p.m., clinical nurse supervisor (CNS)-C stated they could not locate a record of a 30-day supervision for M/ULP-A or ULP-B. CNS-C stated the previous nurse probably did not know one was needed. The licensee's undated Supervision Unlicensed Personnel policy indicated "the direct supervision of staff performing delegated tasks must be provided with in 30 calendar days after the date on which the individual begins working for the facility and first performs 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			
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section	01470			

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01470	Continued From page 18 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation 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 the challenges it poses to communication; (2) 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	01470			

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01470	Continued From page 19 involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure employees received orientation to include all required content for two of two employees (manager/unlicensed personnel (M/ULP)-A, 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 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: M/ULP-A and ULP-B were hired May 8, 2025, and June 18, 2025, respectively to provide direct care for residents of the facility. On June 22, 2026, at 12:20 p.m., the surveyor observed M/ULP-A assist R2 with medication administration. M/ULP-A stated they had in-person training with the RN on medication administration. On June 22, 2026, at 1:24 p.m., the surveyor observed the licensee's undated weekly staff	01470			

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01470	Continued From page 20 schedule. The schedule indicated M/ULP-A and ULP-B each worked 12-hour shifts Monday through Friday. M/ULP-A stated the schedule provided was consistent week to week. M/ULP-A and ULP-B's employee record lacked documentation the following orientation topics were completed prior to providing assisted living services: - review of provider's policies and procedures On June 23, 2026, at 2:00 p.m., clinical nurse supervisor (CNS)-C stated owner (O)-D assigned education to new staff, and he probably did not know a review of the provider's policies and procedures was missing. The licensee's undated Facility Employee Orientation policy indicated staff would complete an orientation on topics required by Minnesota statutes and rules for assisted living, including a review of provider's policies and procedures. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470			
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	01530			

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01530	Continued From page 21 paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure staff completed the required amount of dementia, mental illness, and de-escalation training, in the required time frame for two of two employees	01530			

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01530	Continued From page 22 (manager/unlicensed personnel (M/ULP)-A, 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 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: M/ULP-A and ULP-B were hired May 8, 2025, and June 18, 2025, respectively to provide direct care for residents of the facility. On June 22, 2026, at 12:20 p.m., the surveyor observed M/ULP-A assist R2 with medication administration. On June 22, 2026, at 1:24 p.m., the surveyor observed the licensee's undated weekly staff schedule. The schedule indicated M/ULP-A and ULP-B each worked 12-hour shifts Monday through Friday. M/ULP-A stated the schedule was consistent week to week. M/ULP-A and ULP-B's file lacked evidence of at least eight hours of initial dementia and mental health training in the required topics, within 160 working hours of employment start date. On June 23, 2026, at 12:15 p.m., registered nurse (RN)-C stated M/ULP-A and ULP-B did not have the required hours for dementia care or mental health. RN-C stated owner (O)-D assigned the online training to the staff and	01530			

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01530	Continued From page 23 probably did not know the required number of hours that needed to be assigned. RN-C further stated M/ULP-A and ULP-B worked full time and had worked greater than 160 hours from the time of hire. The licensee's undated Dementia Care Training policy indicated direct care staff would complete at least eight (8) hours of initial training within 160 hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a 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			

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01620	Continued From page 24 (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 observation, interview, and record review, the licensee failed to complete a 14-day assessment and ongoing reassessments that included all required content identified per Minnesota Administrative Rule 4659.0150 Uniform Assessment Tool for two of two residents (R2, R3). This practice resulted in a level two violation (a	01620			

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01620	Continued From page 25 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 R2 was admitted May 5, 2025. R2's service plan dated May 5, 2026, indicated R2 received services including assistance with blood glucose monitoring, medication administration, and behavior management On June 22, 2026, at 12:20 p.m., the surveyor observed manager/unlicensed personnel (M/ULP)-A assist R2 with medication administration. R2's record included an initial comprehensive nursing assessment, dated May 5, 2025, and subsequent RN reassessments on May 18, 2025, and August 2, 2025. The subsequent RN reassessments did not meet the required content identified per Minnesota Administrative Rule 4659.0150 Uniform Assessment Tool. R3 R3 was admitted on January 15, 2026. R3's Service Plan dated January 15, 2026, indicated R3 received services including behavior management, and medication administration. On June 23, 2026, at 9:15 a.m., the surveyor	01620			

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01620	Continued From page 26 observed M/ULP-A assist R3 with medication administration R3's record included a comprehensive nursing assessment dated January 15, 2026, and a subsequent 14-day reassessment dated January 28, 2026. The subsequent RN reassessment did not meet the required content identified per Minnesota Administrative Rule 4659.0150 Uniform Assessment Tool. On June 24, 2026, at 10:24 a.m., clinical nurse supervisor (CNS)-C stated he did not realize the assessment form being used did not meet the Minnesota Administrative Rule 4659.0150 Uniform Assessment Tool required content. The licensee's undated Assessment and Reassessment of Residents policy indicated the RN would conduct an assessment within 14 days of the start of services and assessments would include the requirements outlined in Minnesota Administrative Rule 4659.0150. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41079	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/24/2026
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01640	Continued From page 27 service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a current written service plan included a signature or other authentication by the facility representative, documenting agreement on the services to be provided for two of two residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 was admitted May 5, 2025. R3 was admitted January 15, 2026.	01640			

Minnesota Department of Health

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01640	Continued From page 28 On June 22, 2026, at 12:20 p.m., the surveyor observed manager/unlicensed personnel (M/ULP)-A assist R2 and R3 with medication administration. R2's service plan dated May 5, 2026, indicated R2 received services including assistance with housekeeping, laundry, blood glucose monitoring, medication administration, behavior management, and safety checks. The service plan lacked signature or other authentication by a facility representative documenting agreement on the services to be provided. R3's service plan dated January 15, 2026, indicated R3 received services including assistance with housekeeping, laundry, medication administration, behavior management, and safety checks. The service plan lacked signature or other authentication by a facility representative documenting agreement on the services to be provided. On June 23, 2026, at 12:15 p.m., registered nurse (RN)-C stated R2 and R3's service plans had not been signed by a facility representative. RN-C stated owner (O)-D probably did not know a facility representative needed to sign them. The licensee's undated Service Plan policy indicated the service plan and any revisions would include a signature or other authentication by the assisted living provider and by the resident or resident's representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			

Minnesota Department of Health

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01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to document administration of medications according to provider orders for one of three residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R3's Service Plan dated January 15, 2026, indicated R3 received services including medication administration.	01760			

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01760	Continued From page 30 On June 22, 2026, at 12:50 p.m., the surveyor observed manager/unlicensed personnel (M/ULP)-A assist R3 with medication administration, including two carboxymethylcellulose sodium and glycerin 0.5% drops (used to treat dryness of the eye) to R3's left eye. On June 23, 2026, at 9:15 a.m., the surveyor observed M/ULP-A assist R3 with medication administration, including gabapentin 300 milligrams (mg), by mouth. R3's record included an after visit summary dated February 25, 2026. The visit summary included the following new medications -carboxymethylcellulose sodium and glycerin 0.5% drops: "place 1-2 drops into left eye every 6 hours", and -gabapentin: "Take 1 capsule (300 mg) by mouth once daily in the morning AND 1 capsule (300 mg) once daily in the afternoon AND 2 capsules (600 mg) by mouth once daily at bedtime." R3's medication administration record (MAR), dated June 2026, indicated staff administered carboxymethylcellulose sodium and glycerin 0.5% drops, "Place 1-2 drops into left eye every 6 hours." The MAR indicated the eye drops were administered June 1, 2026 through June 22, 2026, at varying times, including the following: "AM"-times varied between 9:02 a.m., and 11:53 p.m.; "Midday"-times varied between 1:04 p.m., and 11:53 p.m.; "PM"-times varied between 3:07 p.m., and 11:58 p.m.; and "Bedtime"-times varied between 6:28 p.m., and 6:02 a.m.	01760			

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01760	Continued From page 31 The documentation lacked indication the drops were administered every 6 hours, as prescribed, or the reason the administration was not completed as prescribed. R3's MAR, indicated gabapentin 300 mg was scheduled, "once daily in the morning AND 1capsule (300mg) once daily in the afternoon." and "Take 2 capsules (600mg) by mouth once daily at bedtime." The MAR indicated gabapentin was administered June 1, 2026, through June 22, 2026, at varying times: "AM"-times varied between 9:02 a.m., to 11:53 p.m.; "PM"-times varied between 3:37 p.m., to 11:58 p.m.; and "Bedtime"-times varied between 6:28 p.m., and 6:02 a.m. The documentation lacked indication the medication was administered "morning", "afternoon", and "bedtime", as prescribed. On June 23, 2026, at 8:10 a.m., M/ULP-A stated staff, "sometimes give the medication and document it later." M/ULP-A further stated the MAR did not indicate specific times the medication should be given, and they would need to contact the ULP who worked previously to find out the exact time the medication was administered. On June 23, 2026, at 9:35 a.m., clinical nurse supervisor (CNS)-C stated the ULP were "told" to give the medication starting at 6:00 a.m., and every six hours after that. CNS-C stated the medication time stamped entry in the MAR should indicate the time the medications were given, and based on the times listed in the MAR, it looked like R3 was not given the drops every 6 hours as prescribed and it would be considered a	01760			

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01760	Continued From page 32 medication error. CNS-C stated he could see the problems with the current MAR and would change it. The licensee's undated Documentation of Medication Administration policy indicated staff would document medication administration immediately after that task had been performed. The policy further indicated staff would document the reason why medication administration was not administered as prescribed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, and interview, the licensee failed to ensure medications were stored according to manufacturer's instructions. 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	01880			

Minnesota Department of Health

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01880	Continued From page 33 affect a large portion or all of the residents). The findings include: On June 22, 2026, at 12:10 p.m., the surveyor observed the contents of the licensee's medication refrigerator with manager/unlicensed personnel (M/ULP)-A. The refrigerator contained a box containing 5 Lantus insulin injector pens (long-acting insulin used to lower blood sugar), one single Novolog Flex pen (fast-acting insulin used to lower blood sugar), and a box containing 5 additional Novolog Flex pens. The fridge lacked a thermometer to ensure the medications were stored at the appropriate temperature, according to manufacturer instructions. M/ULP-A stated they did not know they were expected to monitor the refrigerator temperature for medication storage. The manufacturer's prescribing information for the use of Lantus insulin pens, revised June 2023, indicated unopened medication should be refrigerated at 36-46 degrees Fahrenheit (F). The manufacturer's prescribing information for the use of NovoLog, insulin aspart injection, dated March 2023, indicated the medication should be refrigerated at 36-46 degrees Fahrenheit (F) when not in use. The licensee's undated Individualized Medication Management Plan and Record policy indicated the registered nurse would develop a medication management plan indicating medications would be stored consistent with the manufacturer's directions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01880			

Minnesota Department of Health

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01880	Continued From page 34	01880			
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were labeled with an opened or beyond-use date for time-sensitive medications for one of one 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 the potential to affect a large portion or all of the residents). The findings include: R2's service plan, dated May 25, 2025, indicated R2 received services including assistance with medication administration. On June 22, 2026, at 12:20 p.m., the surveyor observed manager/unlicensed personnel (M/ULP)-A assist R2 with medication	01890			

Minnesota Department of Health

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01890	Continued From page 35 administration, including 10 Units of Novolog insulin (fast-acting insulin used to lower blood sugar) with an injector pen. R2's insulin pen lacked an opened date to indicated when it was first opened and would expire. On June 23, 2026, at 9:33 a.m., clinical nurse supervisor (CNS)-C stated he created a "date opened sticker" that he wrapped around the pens to date them. CNS-C stated the machine he used to create the sticker was broken and that was why R2's insulin pen lacked an indication when it was first opened. The manufacturer's prescribing information for the use of NovoLog, insulin aspart injection, dated March 2023, indicated the medication should be discarded 28 days after first use. The licensee's undated Individualized Medication Management Plan and Record policy indicated the registered nurse would develop a medication management plan indicating medications would be stored consistently with the manufacturer's directions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and	03090			

Minnesota Department of Health

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03090	Continued From page 36 maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the required posting at each entrance to the facility accessible to visitors, included statutory language to disclose the possibility of electronic monitoring activity. This had the potential to affect all current residents in the assisted living facility, staff, and any visitors to the facility. This practice resulted in a level one violation (a violation that has not 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 potential to affect a large portion or all of the residents). The findings include: On June 22, 2026, at 10:45 a.m., during a tour of the licensee's facility, the surveyor observed the licensee lacked an electric monitoring notice with the required statutory language indicating, "electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." Manager/unlicensed personnel (M/ULP)-A stated there was not an electronic monitoring notice posted at the front entrance, and he was not aware of the requirement The licensee's undated Electronic Monitoring policy indicated the residents, or the resident representative may conduct electronic monitoring	03090			

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03090	Continued From page 37 in the resident's room or private living unit consistent with the consent notification and other requirements set forth in the law. The policy lacked an indication that the licensee would post a sign at each facility entrance accessible to visitors that stated, "electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090			



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

Provisional Assisted Co LLC
223 WINIFRED STREET
St Paul, MN 55107
Ramsey County
Parcel:

Phone:

License Info

License: HFID 41079

Risk:
License:
Expires on:
CFPM: MOHAMUD JAMA
CFPM #: 71741; Exp: 7/1/2027

Inspection Info

Report Number: F8058261149
Inspection Type: Full - Single
Date: 6/22/2026 Time: 2:41:02 PM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 1
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

! New Order: 4-700 Sanitizing Equipment and Utensils

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

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

COMMENT: DISH WASHER DID NOT REACH REQUIRED TEMPERATURE USING TEST STICKER - REPAIR OR REPLACE

Comply By: 8/28/2026 Originally Issued On: 6/22/2026

Food & Beverage General Comment

HRD INSPECTOR TAMMY CARLSON

RESIDENTIAL HOME WITH NON COMMERCIAL APPLIANCES AND FINISHES
TILE FLOOR, WOOD CABINETS, LAMINATE COUNTER, PAINTED SHEETROCK

TOMATO 41, COOLER

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 F8058261149 from 6/22/2026

AWALE NOUR
HOUSE MANAGER

Aaron Gertz,
Public Health Sanitarian 3
651-201-4516
aaron.gertz@state.mn.us

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL41079001-0	Date: June 23, 2026
Facility Name: ASSISTED CO LLC	
Facility Address: 223 WINIFRED STREET ST PAUL MN 55107	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Two (2) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]
2. Lighted matches, cigarettes, cigars or other burning object shall not be discarded in such a manner that could cause ignition of other combustible material. [Minn. Stat. 144G.45 subd. 2; MSFC 310.7]

Comments: Along the front sidewalk there were a few cigarette butts in the mulch and no proper disposal ashtray in the area.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

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

Comments: The alley side of the garage had a large section of siding broken off, and some wood trim around the frame of the door was also broken. This allows elements to enter and damage the structure of the garage.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 3; Widespread

TIME PERIOD OF CORRECTION: Twenty One (21) days

1. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include employee actions to be taken in the event of a fire or similar emergency. [Minn. Stat. 144G.45 subd.2]

Comments: The FSEP 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).

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

Comments: The FSEP did not identify specific fire protection actions for residents. There was no section in the plan that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency.

3. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. [Minn. Stat. 144G.45 subd.2]

Comments: The facility uses an electronic care plan website for standard resident evacuation procedures. The FSEP doesn't include specific resident evacuation procedures and failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents.

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

Comments: The manager/unlicensed personnel, (M/ULP)-A lacked documentation showing any training was offered or training was scheduled for a future date for staff on the fire safety and evacuation plan. M/ULP-A stated that all training was done verbally but not documented.

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

Comments: The M/ULP-A lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. M/ULP-A stated that all training was done verbally but not documented.

6. Evacuation drills are required for employees 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. [Minn. Stat. 144G.45 subd.2]

Comments: Surveyor requested evacuation drill documentation from M/ULP-A. M/ULP-A provided only 3 documented evacuation drills since obtaining their license.