



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 9, 2026

Licensee
Derman Senior Care Inc
6852 7th Street
Coon Rapids, MN 55432

RE: Project Number(s) SL36692016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 17, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. 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 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - \$500.00

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

A handwritten signature in cursive script that reads "Jessie Chenze".

Jessie Chenze, 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: 36692	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/17/2026
NAME OF PROVIDER OR SUPPLIER DERMAN SENIOR CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 6852 7TH STREET COON RAPIDS, MN 55432			
(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: SL36692016-0 On March 16, 2026, through March 17, 2026, 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; one receiving services under the Provisional Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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 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 evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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

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0 480	Continued From page 2 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 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated March 17, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480			

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0 480	Continued From page 3	0 480			
0 485 SS=C	TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates. 144G.41 Subdivision 1.a (a) Minimum requirements; required food services (a) All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed ensure at least three nutritious meals daily, according to the recommended dietary allowances in the United Stated Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables, with records reviewed. This had the potential to affect all current residents. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety)	0 485			

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0 485	Continued From page 4 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 failed to ensure the following: - meals with seasonal fresh fruit and vegetables; and - meals according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines. The licensee had three menu's posted in the kitchen as follows: - March 2026 Breakfast MENU - Sunday resident choice; - Monday pancakes and eggs; - Tuesday resident choice; - Wednesday omelet, fruit smoothie; - Thursday cereal; - Friday oatmeal; and - Saturday waffles and eggs. March 2026 Lunch MENU - Sunday chicken sandwich, fruits; - Monday turkey club; - Tuesday spaghetti and curry; - Wednesday pizza; - Thursday resident choice; - Friday burrito, fruits; and - Saturday tacos. March 2026 Dinner MENU - Sunday turkey sub, fruit salad; - Monday pizza, side salad; - Tuesday hamburgers, fries, apple slices; - Wednesday baked chicken, potato wedges,	0 485			

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0 485	Continued From page 5 fruit smoothie; - Thursday beef tacos, side salad; - Friday steak and veggie stir fry with rice; and - Saturday chicken salad sandwich and fruit smoothie. On March 16, 2026, at 12:40 p.m., the surveyor observed R1 eating lunch in the dining room. R1's plate had approximately 1/4 plate chicken and 1/2 plate of buttered noodles. No fruits or vegetables were noted or offered. At this time, R1 stated they provide his food for him so he does not have to buy groceries. He stated they make him good Somali food which he enjoys. On March 17, 2026, at 12:45 p.m., R1 was observed to make himself some frozen waffles with syrup. On March 17, 2026, at 12:15 p.m., licensed assisted living director (LALD)-B stated "we will need to get better food options." The licensee's Food Service policy dated January 7, 2022, noted meal preparation followed regulatory guidelines including preparation according to the USDA guidelines including seasonal fresh fruit and fresh vegetables, and according to the Minnesota Food Code. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485			
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment	0 550			

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0 550	Continued From page 6 All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post in a conspicuous place, the contact information for the Office of Ombudsman for Long-Term Care (OOLTC), and the Office of Ombudsman for Mental Health and Developmental Disabilities (OOMHDD). This had the potential to affect the licensee's current resident, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 550			

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0 550	Continued From page 7 On March 16, 2026, at 10:50 a.m., during the facility tour with licensed assisted living director (LALD)-B, the surveyor observed postings at the top of the stairs, in the living room area next to the television, and on the wall next to the hallway. The licensee's Grievance policy dated January 7, 2022, lacked: - the contact information for OOLTC and OOMHDD. On March 1, 2026, at 12:00 p.m., LALD-B stated they had the OOLTC information posted on the board, but not on the grievance policy. LALD-B stated she was not familiar with the OOMHDD. 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 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.	0 640			

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0 640	Continued From page 8 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, 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 the licensee's one current resident, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee failed to post information and the reporting number for the Minnesota Adult Abuse Reporting Center (MAARC) to report suspected maltreatment of a vulnerable adult under section 626.557. On March 16, 2026, at 10:50 a.m., during the facility tour with licensed assisted living director (LALD)-B, the surveyor observed postings at the top of the stairs, in the living room area next to the television, and on the wall next to the hallway. However, posting related to MAARC information was not found. On March 1, 2026, at 12:00 p.m., LALD-B stated they thought the information was posted, but was not able to locate it at this time.	0 640			

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0 640	Continued From page 9 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640			
0 650 SS=D	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 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 the employee record contained the required content for one of three employees (clinical nurse supervisor/CNS-A).	0 650			

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0 650	Continued From page 10 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: During the entrance conference on March 16, 2026, at 10:30 a.m., licensed assisted living director (LALD)-B and CNS-A stated they were aware of the required contents of the employee records. CNS-A was hired on November 20, 2021, to provide direct care services to residents and to provide staff supervision at the facility. CNS-A's record lacked documented evidence of the following required annual training: - a review of the provider's policies and procedures. During a phone interview on March 17, 2026, at 11:55 a.m., LALD-B and CNS-A stated the policies had been reviewed, but were not documented in the record as required. The licensee's Personnel Records policy dated January 7, 2022, noted records of annual training would be kept in the personnel record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			

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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 develop a written emergency preparedness plan (EPP) with all the required content defined in Appendix Z. This had the potential to affect residents receiving services under the assisted living license, staff, and visitors. This practice resulted in a level two violation (a	0 680			

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0 680	Continued From page 12 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 March 16, 2026, at 10:50 a.m., during the facility tour with licensed assisted living director (LALD)-B, the surveyor observed the facility to be a split level house. The upper level had a dining room, kitchen, living room, bedrooms, and two bathrooms. The lower level had bedrooms, a common area, and an area used for staff offices. The licensee's white binder titled Emergency Preparedness Manual, dated reviewed August 1, 2025, lacked the following required content: - missing resident plan reviewed quarterly; - policies and procedures to address a system of medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records; - policies and procedures to address volunteers; - communication plan including a method for sharing information and medical documentation for residents under the facility's care, as necessary, with other health care providers to maintain continuity of care; - means, in the event of an evacuation, to release resident information as permitted under 45 CFR 164.510(b)(4); and - exercises to test the EPP at least twice per year, including unannounced staff drills using the EPP. On March 17, 2026, at 12:25 p.m., via phone	0 680			

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0 680	Continued From page 13 interview, LALD-B stated she believed their emergency preparedness plan had this information and would send to by the end of the day. However, the information provided was not specific to the licensee. In addition, LALD-B stated the missing resident plan was reviewed annually, not quarterly. 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 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:	0 775			

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0 775	Continued From page 14 Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated 3/17/2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) 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. 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	0 800			

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0 800	Continued From page 15 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 3/17/2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	0 800			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to	0 810			

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0 810	Continued From page 16 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 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 3/17/2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 810			

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0 900 SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract prior to providing assisted living services for one of one resident (R1).	0 900			

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0 900	Continued From page 18 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: R1 admitted to the facility on August 22, 2022 R1's Assisted Living Contract was dated August 1, 2021. R1's Service Plan dated March 2, 2026, indicated R1 received services including assistance with dressing, grooming, and medication administration. On March 17, 2026, at 12:15 p.m., via phone interview, licensed assisted living director (LALD)-B stated R1 admitted from a sister company, and all companies utilized the same contract, so a new contract was not signed when R1 came to this facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900			
01420 SS=D	144G.62 Subd. 2 Delegation of assisted living services (b) When the registered nurse or licensed health	01420			

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01420	Continued From page 19 professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If the unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted competency testing for one of one unlicensed personnel, (ULP)-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 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: During the entrance conference on March 16, 2026, at 10:30 a.m., licensed assisted living director (LALD)-B and clinical nurse supervisor (CNS)-A stated they were aware of the required	01420			

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01420	Continued From page 20 contents of the employee records. The licensee provided a Current Employee Roster, undated, which noted ULP-C had a hire date of November 1, 2025. On March 16, 2026, from 10:00 a.m. through 2:00 p.m., the surveyor observed ULP-C working at the facility and interacting with the licensee's one resident. On March 17, 2026, at 12:00 p.m. during a phone interview, LALD-B and CNS-A stated ULP-C had left overseas for some time, and they expected her to come back. Dates provided included: - August 21, 2022, was the last date worked before her leave; and - November 15, 2025, was the first date back to work after her return. During the interview, LALD-B and CNS-A stated they had completed a supervision of ULP-C providing a delegated task upon her return on November 21, 2025, but had not performed any competency testing after being gone for this length of time. The licensee's Staff Competency policy dated January 7, 2022, indicated ULP who had not regularly performed the delegated task for a period of 24 consecutive months would demonstrate the competency to the RN or appropriate health professional. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01420			

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01500	Continued From page 21	01500			
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss.	01500			

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01500	Continued From page 22 Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of two employees (unlicensed personnel/ULP-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 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: During the entrance conference on March 16,	01500			

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01500	Continued From page 23 2026, at 10:30 a.m., licensed assisted living director (LALD)-B and clinical nurse supervisor (CNS)-A stated they were aware of the required contents of the employee records. The licensee provided a Current Employee Roster, undated, which noted ULP-C had a hire date of November 1, 2025. On March 16, 2026, from 10:00 a.m. through 2:00 p.m., the surveyor observed ULP-C working at the facility and interacting with the licensee's one resident. ULP-C's record included a transcript of training, all completed in June 2022. The record lacked documented evidence of annual training to include: - reporting maltreatment of vulnerable adults or minors; - assisted living bill of rights; - infection control techniques; - effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; - a review of the provider's policies and procedures; and - principles of person-centered planning and service delivery. On March 17, 2026, at 12:00 p.m., during a phone interview, LALD-B and CNS-A stated ULP-C had left overseas for some time, and they expected her to come back. Dates provided included: - August 21, 2022, was the last date worked before her leave; and - November 15, 2025, was the first date back to work after her return.	01500			

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01500	Continued From page 24 During the interview, LALD-B and CNS-A stated they had completed a supervision of ULP-C providing a delegated task on November 21, 2025, but had not provided any annual training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500			
01530 SS=D	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	01530			

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NAME OF PROVIDER OR SUPPLIER DERMAN SENIOR CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 6852 7TH STREET COON RAPIDS, MN 55432			
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01530	Continued From page 25 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 one of two employees (unlicensed personnel/ULP-C) received the required amount of mental illness and de-escalation training within the required time frame and the required amount of dementia care training in 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 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: The licensee held an assisted living license effective April 1, 2025.	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36692	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/17/2026
NAME OF PROVIDER OR SUPPLIER DERMAN SENIOR CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 6852 7TH STREET COON RAPIDS, MN 55432			
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01530	Continued From page 26 During the entrance conference on March 16, 2026, at 10:30 a.m., licensed assisted living director (LALD)-B and clinical nurse supervisor (CNS)-A stated they were aware of the required contents of the employee records. The licensee provided a Current Employee Roster, undated, which noted ULP-C had a hire date of November 1, 2025. On March 16, 2026, from 10:00 a.m. through 2:00 p.m., the surveyor observed ULP-C working at the facility and interacting with the licensee's one resident. ULP-C's record included a transcript of training, all completed in June 2022. The record lacked documented evidence of training to include: - training in mental illness and de-escalation by July 1, 2025; - annual two hours dementia training; and - one hour annual mental illness and de-escalation training. On March 17, 2026, at 12:00 p.m., during a phone interview, LALD-B and CNS-A stated ULP-C had left overseas for some time, and they expected her to come back. Dates provided included: - August 21, 2022, was the last date worked before her leave; and - November 15, 2025, was the first date back to work after her return. During the interview, LALD-B and CNS-A stated they had completed a supervision of ULP-C providing a delegated task on November 21, 2025, but had not performed any additional training.	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36692	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/17/2026
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01530	Continued From page 27 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			
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 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;	01790			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36692	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/17/2026
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01790	Continued From page 28 (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 licensee failed to ensure the registered nurse (RN) developed comprehensive written procedures for the unlicensed personnel (ULP) providing medications for residents having unplanned time away when the licensed nurse was not available. 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	01790			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36692	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/17/2026
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01790	Continued From page 29 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: During the entrance conference on March 16, 2026, at 10:30 a.m., licensed assisted living director (LALD)-B and clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to the licensee's residents. The licensee's Medication Management Plan for Residents Away from Home policy dated January 7, 2022, noted the RN would develop written procedures. However, the procedures lacked: - the type of container or containers to be used for the medication appropriate to the provider's medication system; - how the ULP must document in the resident record that medications had been provided, including documentation of the date the medications were provided and who received the medications; and - how the RN would be notified that medications had been provided and whether the RN needed to be notified before the medications were given to the resident. On March 17, 2026, at 11:40 a.m. via telephone interview, LALD-B and CNS-A stated the procedures should all be included in the policy and would look and provide. However, the information provided lacked the above content. No further information was provided.	01790			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36692	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/17/2026
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01790	Continued From page 30	01790			
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 maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the required notice was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity. This had the potential to affect the licensee's one current residents, staff, and any visitors of the licensee. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Upon entrance on March 16, 2026, at 10:10 a.m., the surveyor observed the outside of the entrance to the facility. No sign regarding electronic monitoring was noted.	03090			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36692	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/17/2026
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03090	Continued From page 31 During the facility tour on March 16, 2026, at 10:50 a.m., with licensed assisted living director (LALD)-B, the surveyor observed postings inside the building entrance. However, no sign was noted regarding electronic monitoring. On March 16, 2026, at 12:00 p.m., LALD-B stated the sign was usually posted but was unable to locate it at this time. 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

DERMAN SENIOR CARE INC
6852 7TH ST NE
Fridley, MN 55432
Anoka County
Parcel:

Phone:

License Info

License: HFID 36692

Risk:
License:
Expires on:
CFPM: Marian M. Mohamed
CFPM #: 10273; Exp: 03/01/2027

Inspection Info

Report Number: F1021261087
Inspection Type: Full - Single
Date: 3/17/2026 Time: 1:13:57 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 1
Total Priority 2 Orders: 2
Total Priority 3 Orders: 5
Delivery: Emailed

! New Order: 2-200 Employee Health

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

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

COMMENT: NO EMPLOYEE ILLNESS LOG ON-SITE. DISCUSSED EMPLOYEE ILLNESS POLICY AND RECORDING WITH MANAGER. AN MDH EMPLOYEE ILLNESS LOG SENT WITH REPORT. PRINT AND KEEP A COPY ON-SITE.

Comply By: 3/19/2026 Originally Issued On: 3/17/2026

New Order: 3-300C Protection from Contamination: equipment/utensils, consumers

3-307.11 Priority Level: Priority 3 CFP#: 39

MN Rule 4626.0337 Protect food from miscellaneous sources of contamination.

COMMENT: OBSERVED A BOX OF FROZEN REPTILE FOOD STORED IN THE CHEST FREEZER. THE PACKAGING CLEARLY STATES THAT THE FOOD IS NOT INTENDED FOR HUMAN CONSUMPTION. PER CONVERSATION WITH THE FOOD MANAGER, THEIR CLIENT HAS A SNAKE IN THEIR ROOM. STAFF WILL ENSURE THE REPTILE FOOD IS STORED IN A SEPARATE FREEZER, COMPLETELY APART FROM OTHER FOOD ITEMS.

Comply By: 3/19/2026 Originally Issued On: 3/17/2026

New Order: 4-200 Equipment Design and Construction

4-204.112A Priority Level: Priority 3 CFP#: 36

MN Rule 4626.0620A Provide a temperature measuring device located in the warmest part of mechanically refrigerated units and coolest part of hot food storage units that are capable of measuring air temperature or a simulated product temperature.

COMMENT: THERE WAS NO THERMOMETER IN THE KITCHEN REFRIGERATOR TO CHECK THE AMBIENT TEMPERATURE. PROVIDE AS DESCRIBED IN RULE ABOVE.

Comply By: 3/27/2026 Originally Issued On: 3/17/2026

New Order: 4-300 Equipment Numbers and Capacities

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

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

COMMENT: NO TEST KIT ON-SITE TO MEASURE THE CONCENTRATION OF CHLORINE. PROVIDE.

Comply By: 3/24/2026 Originally Issued On: 3/17/2026

New Order: 4-600 Cleaning Equipment and Utensils4-601.11C *Priority Level: Priority 3 CFP#: 49*

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

COMMENT: THE AREA BELOW THE MICROWAVE AND VENTILATION HOOD FILTERS SHOWS AN ACCUMULATION OF GREASE. CLEAN AND MAINTAIN CLEAN.

Comply By: 3/23/2026 Originally Issued On: 3/17/2026

New Order: 5-200C Plumbing: Maintenance, fixture location5-205.11AB *Priority Level: Priority 2 CFP#: 10*

MN Rule 4626.1110AB The handwashing sink must be accessible at all times for employee use, and must be used only for handwashing.

COMMENT: DIRTY PLATES WERE OBSERVED IN THE DESIGNATED HANDWASHING COMPARTMENT OF THE KITCHEN'S TWO COMPARTMENT SINK. THEY WERE REMOVED DURING INSPECTION. CORRECTED ON-SITE. DISCUSSED THAT THE HANDWASHING SINK MUST REMAIN ACCESSIBLE AT ALL TIMES DURING OPERATION AND IS TO BE USED EXCLUSIVELY FOR HANDWASHING PURPOSES ONLY.

Comply By: Complied On Site Originally Issued On: 3/17/2026

New Order: 6-200 Physical Facility Design and Construction6-201.14A *Priority Level: Priority 3 CFP#: 55*

MN Rule 4626.1350A Remove carpeting or similar material from the following unapproved areas: food preparation areas; walk-in refrigerators or freezers; warewashing areas; toilet room areas where handwashing sinks, toilets and urinals are located; refuse storage areas; wait stations; dressing rooms; locker rooms; janitorial areas; within 3 feet around permanently installed bars and salad bars, other food service equipment, and food storage rooms; or other areas where the floor is subject to moisture, flushing, or spray cleaning methods.

COMMENT: THERE IS A CHEST FREEZER IN THE KITCHEN PLACED OVER CARPETED FLOORING. EITHER REMOVE THE CHEST FREEZER OR PROVIDE A PLASTIC MAT TO ALLOW THE AREA TO BE PROPERLY CLEANED.

Comply By: 3/30/2026 Originally Issued On: 3/17/2026

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control6-501.11 *Priority Level: Priority 3 CFP#: 55*

MN Rule 4626.1515 Maintain the physical facilities in good repair.

COMMENT: THE BACKWALL SPLASH TILES BEHIND THE HANDWASHING SINK ARE MISSING. RECOMMEND EITHER REMOVING ALL TILES FOR REPLACEMENT OR REPAIRING THE MISSING TILES TO RESTORE THE WALL SURFACE.

Comply By: 3/31/2026 Originally Issued On: 3/17/2026

Food & Beverage General Comment

All findings on this report were discussed with Food Manager Marian Mohamed and Health Regulation Division Nurse Evaluator, Annette Truebenbach.

This facility is a residential home, and they currently have 1 client and the facility can accommodate up to 4 clients.

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

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

Establishment has an NSF certified residential dishwasher and temperature indicator on-site.

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

The kitchen has residential equipment, vinyl floors and painted drywall. Physical facility items will be monitored during future

inspections.

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 F1021261087 from 3/17/2026

Melissa Ramos

Marian Mohamed
Food Manager

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



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

Temperature Observations/Recordings

Page: 1

Establishment Info

DERMAN SENIOR CARE INC
Fridley
County/Group: Anoka County

Inspection Info

Report Number: F1021261087
Inspection Type: Full
Date: 3/17/2026
Time: 1:13:57 PM

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

Location: Kitchen Refrigerator at 38 Degrees F.

Comment:

Violation Issued?: No

Equipment Temperature: Product/Item/Unit: Kitchen Refrigerator ; Temperature Process: Ambient Air

Location: Kitchen at 36 Degrees F.

Comment:

Violation Issued?: No

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL36692016-0	Date: 3/17/2026
Facility Name: Derman Senior Car Inc.	
Facility Address: 6852 7th St NE, Fridley, Minnesota 55432	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]
2. Egress doors shall be readily operable from the egress side without the use of a key or special knowledge. [Minn. Stat. 144G.45 subd. 2; MSFC 1010.1.9]

Comments: A sliding bolt lock was observed installed on the basement egress door. The locking mechanism requires manual disengagement and may impede immediate egress, creating a potential life safety hazard.

3. A means of egress shall be free from obstructions that would prevent its use, including the accumulation of snow and ice. Means of egress shall remain free of any material or matter where its presence would obstruct or render the means of egress hazardous. No combustible material storage is allowed in the corridors or exit stairs. [Minn. Stat. 144G.45 subd. 2; MSFC 1031.3]

Comments: The evacuation map indicated an exit path from the living space through the garage to exit. The exit path shall not indicate exiting through the garage in the event of a fire or similar emergency as this space is a higher hazard space than the assisted living. Basement exit did not provide a path to the public way due to build up of snow and ice.

4. Where smoking is permitted, suitable noncombustible ash trays or match receivers shall be provided on each table and at other appropriate locations. [Minn. Stat. 144G.45 subd. 2; MSFC 310.6]

Comments: During the survey, cigarette butts were observed discarded inside a plastic flowerpot located on the basement patio.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Twenty One (21) 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: Inside the garage, there was an excessive accumulation of combustible materials piled over five feet above the ground. The items in storage included, but were not limited to, cardboard boxes, dining and bedroom furniture, lamps, paper bags, and other household goods. There was nothing securing the stored items that would prevent them from falling on staff or residents who were inside the garage. Along with combustible storage, there were chemical accelerants stored in the same area above and immediately adjacent to the combustible storage. These chemicals included old paint cans, fuel cans, and multiple gas cans. The storage conditions created a fire hazard and impeded safe access and movement within the space. The garage was identified as part of the emergency egress path to exit the facility in case of a fire.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

1. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include the location and number of resident rooms. [Minn. Stat. 144G.45 subd.2]

Comments: The bedrooms were not labeled on the egress maps.

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

Comments: The FSEP did not 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.

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

Comments: The FSEP failed to provide specific procedures for staff to assist with resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents.