Electronically Delivered

August 21, 2025

Licensee
Unitedcare Assist LLC
3417 26th Avenue South
Minneapolis, MN 55406

RE: Project Number(s) SL38678016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 3, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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 . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

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

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,

Renee L. Anderson

Renee L. Anderson, Supervisor
State Evaluation Team
Email: Renee.L.Anderson@state.mn.us
Telephone: 651-201-5871 Fax: 1-866-890-9290

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38678	A. BUILDING: _____ B. WING _____	07/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITEDCARE ASSIST LLC	3417 26TH AVENUE SOUTH MINNEAPOLIS, MN 55406

(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: SL38678016-0 On June 30, 2025, through July 3, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there was one resident; one receiving services under the 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		

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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 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 July 1, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		

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0 650	Continued From page 3	0 650		
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 infomation: (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 two of two employees (registered nurse (RN)-B and unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	0 650		

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0 650	Continued From page 4 cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: RN-B had a hire date of June 1, 2022. ULP-D had a hire date of March 15, 2024. On July 1, 2025, at 10:50 a.m., the surveyor observed ULP-D assist residents with medication administration. RN-B and ULP-D's records lacked evidence of an annual performance review. On July 1, 2025, at 12:05 p.m., licensed assisted living director (LALD)-A verified he had not completed annual performance reviews for RN-B or ULP-D. LALD-A stated he was aware of the requirement, and was working with a consultant to complete annual training and the annual performance reviews for RN-B and LALD-A. The licensee's Employee Records policy, dated August 1, 2022, verified the employee record would include documentation of annual performance reviews that "identify areas of improvement needed and training needs." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		

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0 775	Continued From page 5	0 775		
0 775 SS=E	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain facility in compliance with Minnesota State Fire Code under Minnesota Rules Chapter 7511. This had the potential to affect some residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On July 1, 2025, from approximately 11:20 a.m. to 1:05 p.m., the surveyor toured the facility with director (D)-E. During the tour, the surveyor observed the following deficient conditions: Multiplug adapters were in use in resident room 2 bathroom and bed area, resident room 1, the basement common room, and in the laundry room. The supplied multiplug adapters are not rated for continuous use and may pose a fire risk. D-E acknowledged the use of the multiplug adapters and indicated that they would conduct further training with residents to avoid use of such	0 775		

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0 775	Continued From page 6 devices. There was significant buildup of lint behind the dryer in the laundry room which poses a risk of fire. D-E acknowledged the lint and indicated it would be cleaned up. On July 1, 2025, the surveyor explained to D-E the requirements for multiplug adapters. D-E stated they understood requirements and would make appropriate changes. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 780 SS=E	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except	0 780		

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0 780	Continued From page 7 that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide interconnected smoke alarms throughout the facility. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On July 1, 2025, from approximately 11:20 a.m. to 1:05 p.m., the surveyor toured the facility with director (D)-E. During the tour, the surveyor observed the following deficient conditions: The smoke alarm provided in the laundry room was passed 10 years in age and was not functional when tested. Smoke alarms must be maintained in proper working order. When tested, smoke alarms provided in upper-level bedroom hallway, lower-level bedroom hallway and laundry room were not	0 780		

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0 780	Continued From page 8 interconnected such that activation of one alarm activates all alarms. Smoke alarms were tested by D-E in resident sleeping room 1 and only the alarms in resident rooms sounded. The hardwired alarms provided in the upper-level hallway, lower-level hallway, and laundry room must maintain their power supply, and must also be interconnected with other supplied smoke alarms in the facility. Smoke alarms must be interconnected so activation of one alarm activates all alarms within the facility. During the facility tour interview on July 1, 2025, D-E verified the above-listed fire protection and physical environment observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation	0 800		

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0 800	Continued From page 9 with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 1, 2025, from approximately 11:20 a.m. to 1:05 p.m., the surveyor toured the facility with director (D)-E. During the tour, the surveyor observed the following deficient conditions: The window crank in resident room 1 was missing a screw and loosely attached, making it difficult to open the window. Window crank should be properly and securely attached to the assembly allowing for the window to be readily opened. One window in resident room 2 was damaged and inoperable, being unable to open during the survey. A bathroom drawer in resident room 2 was missing hardware and was taped over rendering it unusable. The bathroom fan in the bathroom attached to resident room 2 was not functional when tested. Bathroom ventilation should be maintained to allow proper ventilation of moisture.	0 800		

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0 800	Continued From page 10 A window crank was missing from window assembly in resident room 4. Windows should be maintained functional, with all supplied hardware. The ground fault interrupter outlet in the upper-level bathroom was not functioning properly and did not trip upon testing. The closet door in the upper-level bathroom was not properly fitted to the closet opening and it did not open properly. The handle to the closet near the front door of the facility was missing and surrounding area damaged, with a hole left in the door. The cover provided around the light switch in the garage did not properly cover the electrical fixture and exposed wires. The switch should be outfitted with a properly fitting cover that prevents access to the wiring. A baluster of the railing along the front porch was missing and exposed screws along the top and bottom of the rail assembly. The railing should be repaired and maintained in safe and proper order. The gutters on the facility were missing downspouts and were damaged, leading to water leaking and pooling around the base of the facility. During the facility tour interview on July 1, 2025, D-E verified the above listed physical environment observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		

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0 810	Continued From page 11	0 810		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the 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:	0 810		

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0 810	Continued From page 12 Based on observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 1, 2025, at approximately 12:30 p.m., director (D)-E and licensed assisted living director (LALD)-A provided documents on the fire safety and evacuation plan (FSEP), and evacuation drills for the facility. The licensee FSEP failed to include the following: The FSEP failed to identify specific fire protection actions for residents. There was no section in the provided documents that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP failed to identify specific fire protection actions for employees. There was no section in the provided documents that addressed the responsibilities or basic evacuation procedures that employees should follow in case of a fire or similar emergency. Documents hanging on the facility walls entitled evacuation plan and escape plan provided general information but did not	0 810		

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0 810	Continued From page 13 have site specific information. Multiple documents were submitted to the surveyor, but no plan with employee actions was available in the FSEP binder. The garage was marked as an emergency exit in the FSEP, which is not appropriate for this facility as it is an area of higher hazard. Record review indicated the licensee failed to provide training to residents at least once per year. LALD-A and D-E were unable to provide documentation showing any training offered or training scheduled for a future date for residents on the fire safety and evacuation plan. Residents who are capable of assisting in their evacuation should be provided training at least once a year. Record review indicated the licensee failed to provide and document adequate training to employees on the FSEP upon hire and at least twice per year. LALD-A provided documentation that general fire safety information was provided to employees upon hire, but the documents did not indicate any site-specific fire safety information was provided. The documents also did not indicate any further ongoing training on the FSEP for employees. Employees should be provided training upon hire and at least twice a year thereafter. Record review indicated that identification of unique resident needs for evacuation was not developed. No documentation was provided to the surveyor outlining unique or unusual resident needs for evacuation. LALD-A and D-E stated that they had not identified such information. The FSEP should include procedures for resident movement or evacuation including identifying their unique or unusual needs for movement or evacuation.	0 810		

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0 810	Continued From page 14 Fire drill records were provided to the survey indicating that drills occurred on 1/8/25, 2/20/25, 4/24/25, and 6/25/25. No records were provided for drill conducted in 2024 or previous years. LALD-A and D-E could not locate records of fire drills prior to 2025. Drills should be occurring at least twice per year per shift and at least once every other month. During an interview on July 1, 2025, at approximately 12:50 p.m., the surveyor explained the requirements for employee trainings, resident trainings, FSEP documentation, and evacuation drills. LALD-A and D-E stated they understood the requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01470 SS=D	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 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	01470		

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01470	Continued From page 15 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 involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.	01470		

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01470	Continued From page 16 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure licensee employees received orientation to include all required content for one of two employees (registered nurse (RN)-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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: RN-B had a hire date of June 1, 2022. RN-B's employee record lacked documentation the following orientation topics were completed prior to RN-B providing assisted living services: -an overview of 144G, -an introduction and review of the facility's policies and procedures related to the provision of assisted living services, -handling of emergencies and use of emergency services, -compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC), -the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights, - the principles of person-centered planning and	01470		

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01470	Continued From page 17 service delivery and how they apply to direct support services provided by the staff person, -handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints, -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 -a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. On July 1, 2025, at 1:32 p.m., RN-B confirmed she had not completed the above required training. RN-B stated she was unaware the training needed to be completed, and would ensure she completed the Educare training. The licensee's Employee Records policy, dated August 1, 2022, indicated the employee record will include "records of all training and in-service education required and/or provided including records of competency testing as required." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training	01500		

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01500	Continued From page 18 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. 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:	01500		

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01500	Continued From page 19 (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received at least eight hours of annual training in the required topics for each 12 months of employment for two of two employees (registered nurse (RN)-B and unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: RN-B and ULP-D had a hire dates of June 1, 2022, and March 15, 2024, respectively. RN-B and ULP-D's employee training records lacked evidence RN-B and ULP-D had	01500		

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01500	Continued From page 20 successfully completed annual training as required in the following areas: -training on reporting of maltreatment of vulnerable adults under section 626.557; -review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -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; -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; -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 -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On July 1, 2025, at 12:05 p.m., licensed assisted living director (LALD)-A confirmed RN-B and ULP-D lacked annual training. LALD-A stated he was aware of the requirement, and was working with a consultant to complete annual training requirements for RN-B and LALD-A. The licensee's Annual Required Staff Training policy, dated August 1, 2022, indicated "all staff that perform direct care services at [facility] will	01500		

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01500	Continued From page 21 complete at least eight (8) hours of annual training for each 12 months of employment." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01530 SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation	01530		

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01530	Continued From page 22 and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure employees completed dementia care training (at least eight hours within 120 working hours of the employment start date) for one of two employees (registered nurse (RN)-B), and two hours of initial training on mental illness and de-escalation topics for two of two employees (RN-B and unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: RN-B and ULP-D had a hire dates of June 1, 2022, and March 15, 2024, respectively.	01530		

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01530	Continued From page 23 RN-B's employee record lacked documentation RN-B completed the following: - initial eight hours of training related to dementia care, within 120 working hours of RN-B's employment start date, - two hours of initial training on mental illness and de-escalation topics. ULP-D's employee record did not contain documentation ULP-D completed the initial two hours of training on mental illness and de-escalation topics. On July 1, 2025, at 12:05 p.m., licensed assisted living director (LALD)-A confirmed RN-B lacked eight hours of training on dementia care and two hours of training on mental illness and de-escalation topics. In addition, ULP-D lacked eight hours of annual training. LALD-A stated he was aware of the requirement, and was working with a consultant to develop and complete training on mental illness and de-escalation topics for all licensee employees and annual training for RN-B and LALD-A. The licensee's Annual Required Staff Training policy, dated August 1, 2022, indicated all staff that perform direct care services will complete at least eight (8) hours of annual training for each 12 months of employment. The policy lacked documentation of two hours of required training on mental illness and de-escalation topics. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01530		

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01770	Continued From page 24	01770		
01770 SS=D	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure documentation of medication set-up was completed at the time of set-up, and included dates of medication set-up, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication set-up, for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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's service plan, dated April 10, 2025, indicated R1 received services including assistance with medication management. On July 1, 2025, at 10:50 a.m., the surveyor observed unlicensed personnel (ULP)-D assist R1 with medication administration from a mediset (medication dispenser). ULP-D stated the RN set	01770		

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01770	Continued From page 25 up the medications in the mediset, and the ULPs administered the medications from the mediset. Prior to administering the medications, the ULPs would count the medications to ensure the number of medications in the mediset match the medications scheduled in the medication administration record. R1's record lacked documentation of medication set-up to include: the date of medication set-up, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication set-up must be done at the time of set-up. On July 1, 2025, at 1:32 p.m., RN-B confirmed the medications set up by the RN did not contain the above required documentation. RN-B stated she was not aware of the requirement. The licensee's Medication Management-Administration & Setup policy, dated August 1, 2022, indicated the "licensed nurse will set up medications in dosage boxes for the resident, usually on a weekly basis, and will make or direct changes between set ups when necessary. ULP will verify medications are set up correctly in the dosage box before administration to the resident by use of the medication profile." The policy did not address documentation of medication set-up to include: the dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		

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625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Unitedcare Assist LCC
3417 26th Avenue South
Minneapolis, MN 55406
Hennepin County
Parcel:

Phone:

License Info

License: 0041243

Risk:
License: -1
Expires on: 12/31/2023
CFPM: Kamal Hussein
CFPM #: CFPM-45531; Exp: 02/12/2028

Inspection Info

Report Number: F1039251046
Inspection Type: Full - Single
Date: 7/1/2025 Time: 11:15:00
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 1
Total Priority 3 Orders: 0
Delivery: Emailed

New Order: 3-500C Microbial Control: date marking
3-501.17B *Priority Level: Priority 2 CFP#: 23*
MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.
COMMENT: OPEN PACKAGES OF COOKED HOT DOGS, CHEESE LACK DATE MARKS. INSTRUCTED PERSON-IN-CHARGE TO DATE MARK THESE FOODS AND USE WITHIN 7 DAYS OF LESS.
Comply By: 7/1/2025 Originally Issued On: 7/1/2025

Food & Beverage General Comment

MILK - COLD HOLD IN REFRIGERATOR - 36 DEGREES F
FREEZER - FROZEN
DISHWASHING MACHINE (RESIDENTIAL NSF CERTIFIED) - 156 DEGREES F BY UST THERMOMETER

The inspection was completed with the person in charge and reviewed with MDH nurse evaluator Jolene Bertelsen.

The kitchen is of residential build and should serve food for same-day service only.

The kitchen has wood cabinets with hollow base and laminate countertops, laminate wood floor, painted walls and ceiling. These kitchen finishes and surfaces are in good repair, clean and well maintained.

The kitchen refrigerator/freezer are of residential grade.

A 2-compartment sink is present in kitchen. 1 compartment is designated for handwashing only.

A residential dishwashing machine is present in the kitchen. Operator had run dish machine with UST thermometer shortly before this inspection.

Verified hand sink correctly set-up, gloves, illness policy, probe thermometer.

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

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Metro District Office inspection report number F1039251046 from 7/1/2025

Kamal Hussein
person-in-charge

Aron Goodner,
Public Health Sanitarian 1
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