Electronically Delivered

April 8, 2025

Licensee
Zubeer Group Home LLC
1567 County Road I
Arden Hills, MN 55126

RE: Project Number(s) SL35989016

Dear Licensee:

On March 10, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the December 11, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

JMD

Electronically Delivered

February 6, 2025

Licensee
Zubeer Group Home LLC
1567 County Road I
Arden Hills, MN 55126

RE: Project Number(s) SL35989016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 11, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35989	A. BUILDING: _____ B. WING _____	12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZUBEER GROUP HOME LLC	1567 COUNTY ROAD I ARDEN HILLS, MN 55126

(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: SL35989016-0 On December 9, 2024, through December 11, 2024, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 4 residents, all of whom were receiving services under the provider's 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR), dated December 10, 2024, 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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0 485	Continued From page 3	0 485		
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services 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 interview and record review, the licensee's assisted living contract required residents to pay for meals, housekeeping, and laundry services. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a 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: R3's current service plan, dated November 1,	0 485		

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0 485	Continued From page 4 2024, indicated R3 received services to include medication management, behavior management, grooming and housekeeping. R3's Resident Contract for Assisted Living, signed October 25, 2024, was identified by registered nurse (RN)-A as the licensee's current assisted living contract. Page 13 of the contract indicated the resident would pay for three meals a day, weekly housekeeping, and weekly laundry as part of the monthly base fee. The contract lacked an option to choose not to pay for any of the included meals. On December 11, 2024, at 10:45 a.m., RN-A stated the language in the contract was meant for private pay residents and should not be used for all residents. RN-A further stated the licensee would need to remove the required meals, housekeeping, and laundry from the assisted living contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that	0 660		

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0 660	Continued From page 5 covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). The licensee failed to ensure screening for active TB (either by a two-step tuberculin skin test (TST) or a single interferon gamma release assay (IGRA) blood test was completed and documented for one of two employees (registered nurse(RN)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The licensee's TB facility risk assessment, dated October 1, 2024, indicated the facility was a "low" risk for TB transmission. RN-A was hired February 17, 2023, to provide direct cares and services to residents, supervise staff and perform managerial duties.	0 660		

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0 660	Continued From page 6 On December 9, 2024, to December 11, 2024, during the survey period, RN-A was observed supervising staff and performing managerial duties in the facility. RN-A's employee record contained an IGRA blood test, dated June 29, 2022, greater than 90 days (233 days) prior to hire. On December 11, 2024, at 9:50 a.m., RN-A stated she thought the blood test was good for one year and she would change her process. The Minnesota Department of Health (MDH) guidelines, "Regulations for Tuberculosis Control in Minnesota Health Care Settings", dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include the following: a team responsible for TB infection control; a facility TB risk assessment; written TB infection control procedures; and HCW education. The guidelines also indicate an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST-tuberculin skin test (first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients. Baseline TB screening should be documented in the employee's record. The licensee's 8.16 Tuberculosis Screening policy, dated August 1, 2021, indicated baseline testing would be completed upon hire and would consist of either a two-step TST or single IGRA blood test. No further information was provided.	0 660		

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0 660	Continued From page 7 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all	0 680		

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0 680	Continued From page 8 residents receiving services under the assisted living license. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's emergency disaster preparedness plan, last reviewed March 8, 2024, lacked evidence of the following required content: - a description of the population served by the licensee; - quarterly review of missing resident policy; - communication plan containing all required elements; - hazard vulnerability assessment; - process for emergency plan collaboration; - subsistence needs for staff and residents; - policies and procedures for volunteers; - roles under a wavier declared by secretary; - names and contact information; - emergency officials contact information; - methods for sharing information; - sharing information on occupancy and needs; and - long term care family notifications. On December 10, 2024, at 10:30 a.m., registered nurse (RN)-A stated licensee had purchased an EPP from a third party, but they had not customized it to the facility yet and were still working on completing it.	0 680		

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0 680	Continued From page 9 The licensee's 9.01 Emergency Preparedness Plan - Appendix Z Compliance policy, dated August 1, 2021, indicated "[licensee] emergency preparedness plan will include all required elements of appendix Z. The plan will be in writing and reviewed annually. The plan is based on our assisted living-based and community-based risk assessments, utilizing an all-hazards approach." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=I	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;	0 780		

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0 780	Continued From page 10 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with Minnesota Fire Code, Minnesota Rules 7511. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a 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 December 9, 2024, at 11:05 a.m., the surveyor toured the facility with unlicensed personnel (ULP)-B. The egress windows in resident bedrooms rooms were opened by ULP-B and measured by the surveyor. The egress windows in occupied resident sleeping rooms R1 and R2 did not meet the minimum requirements for safe egress. EGRESS WINDOWS Egress window measurements: Resident sleeping room R1 - the clear open area of window measured 36.25 inches width, 18 inches height, with a total clear area of 652 square inches.	0 780		

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0 780	Continued From page 11 Resident sleeping room R2 - the clear open area of window #1 measured 28.5 inches width, 18.125 inches height, with a total clear area of 516 square inches. The clear open area of window #2 measured 28.5 inches width, 18.125 inches height, with a total clear area of 516 square inches. One window in each resident bedroom must meet the minimum window opening size of at least 20 inches in width and, a minimum height of 20 inches, with a total clear area of at least 648 square inches (4.5 square feet). SMOKING MATERIAL DISPOSAL On December 9, 2024, at 11:05 a.m., the surveyor toured the facility with unlicensed personnel (ULP)-B. During the tour, the surveyor observed the following: 1. In occupied resident sleeping room R1, a burnt cigarette had been disposed of on the carpeted floor. One of the batteries was missing from the battery-operated sleeping room smoke alarm. The smoke alarm was not working at the time of the tour. 2. In occupied resident sleeping room R2, multiple burnt cigarettes had been disposed of on the carpeted floor. There were burn marks observed on the carpet, both windowsills, and on bedding. During the facility tour interview on December 9, 2024, ULP-B verified the egress window measurements and improper smoking material disposal. TIME PERIOD FOR CORRECTION: Immediate On December 9, 2024, at 11:05 a.m., the	0 780		

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0 780	Continued From page 12 surveyor toured the facility with ULP-B. During the tour, the surveyor observed the following: 1. In the basement, an extension cord was plugged into a laundry room outlet and was taped to the floor. This extension cord ran from the laundry room into the hallway and then under the door into occupied resident sleeping room R4. In the employee office, power strips were daisy chained together to provide power for office equipment. Improper use of extension cords and power strips creates a fire hazard. 2. In occupied resident sleeping room R3, the path to the egress window was obstructed by the storage of personal items in front of the window. The improper placement of furniture and personal items could delay exiting in the event of an emergency. 3. In occupied resident sleeping room R1, one of the smoke alarm batteries had been removed from the smoke alarm and this alarm did not work when tested by ULP-B. Smoke alarms must be maintained in operating condition. 4. In the designated outdoor smoking area, trash had been disposed of in the receptacle used for smoking material disposal, creating a fire hazard. During the facility tour interview on December 9, 2024, ULP-B verified the above listed observations. TIME PERIOD FOR CORRECTION: Two (2) days	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a	0 790		

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0 790	Continued From page 13 minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers as required by statute. This deficient condition had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 December 9, 2024, at 11:05 a.m., the surveyor toured the facility with unlicensed personnel (ULP)-B. During the tour, the surveyor observed inspections had not been recorded on the back of the tag attached to the portable fire extinguisher in the basement since the annual maintenance inspection had been completed in October 2024. Fire extinguisher inspections must be conducted every month to ensure each extinguisher is in its designated place, it has not been tampered with, and there is no obvious physical damage or condition that would interfere	0 790		

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0 790	Continued From page 14 with its use or operation. During the facility tour interview on December 9, 2024, ULP-B verified the monthly fire extinguisher inspection frequency was not met. Additionally, the licensee had recorded monthly fire extinguisher inspections completed prior to October 2024 on the back of the annual maintenance tags dated October 2024. To ensure proper maintenance of the installed fire extinguishers, only monthly inspections completed after the annual maintenance inspection should be recorded on the back of the tags attached to the fire extinguisher in order to accurately reflect the current status of the extinguisher. During the facility tour interview on December 9, 2024, ULP-B verified the above listed observations. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
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:	0 800		

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0 800	Continued From page 15 Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect a limited number of 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 December 9, 2024, at 11:05 a.m., the surveyor toured the facility with unlicensed personnel (ULP)-B. During the tour, the surveyor observed the following: 1. In occupied resident room R3, the bedroom door panel was cracked and taped. 2. In occupied resident room R2: - The window blind was in disrepair. - The cover was missing from the ceiling light fixture. - The door knob was loose on the bedroom door. - One section of base trim was broken. - The carpet was stained and had burn marks. 3. The window screen was bent and did not form a seal with the window frame in the main floor resident bathroom. During the facility tour interview on December 9, 2024, ULP-B verified the above listed observations.	0 800		

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0 800	Continued From page 16 TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	0 810		

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0 810	Continued From page 17 This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to develop a fire safety and evacuation plan with the required content, and provide required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 9, 2024, unlicensed personnel (ULP)-B provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and employee evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee FSEP had not been developed and maintained for the facility location. On December 9, 2024, at 11:05 a.m., the surveyor toured the facility with unlicensed personnel (ULP)-B. During the tour, the surveyor observed the following: 1. The fire evacuation floor plan failed to include an accurate layout of the facility. 2. The location of resident sleeping rooms was not accurately identified; room identifiers were not posted on or at the resident sleeping room doors. ULP-B verbally identified resident sleeping rooms	0 810		

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0 810	Continued From page 18 as R1, R2, R3, and R4 during the tour. Room identifiers installed at the resident sleeping room doors must correspond with the FSEP floor plan to provide efficient communication for exiting in the event of a fire or similar emergency. 3. The fire evacuation floor plan failed to identify the main emergency exit for the facility. ULP-B verbally identified the front and back doors as emergency exits and exit signs were posted at these doors. The fire evacuation floor plan did not label the front door as an exit. Exit labels are required to be included on the FSEP floor plan in order to direct occupants to the exits in the event of an emergency. During the facility tour interview on December 9, 2024, ULP-B verified the above listed observations. The FSEP included standard employee procedures, but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The employee actions were limited to the RACE (Remove, Alarm, Confine, Extinguish/Evacuate) acronym. The FSEP failed to include specific fire protection procedures necessary for residents evident by no procedures in the plan. The FSEP included standard resident evacuation procedures, but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency. During an interview on December 9, 2024, at 2:15 p.m., ULP-B verified the FSEP required revision.	0 810		

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0 810	Continued From page 19 TRAINING Record review indicated that the licensee failed to provide training to employees on the FSEP at least twice per year after hire evident by the lack of training documentation to support this has been completed. An emergency and disaster employee training record was provided for review. During an interview on December 9, 2024, at 2:15 p.m., ULP-B stated that emergency and disaster training included FSEP training and was completed at the time of hire and then annually. No additional employee FSEP training records were provided. DRILLS Record review indicated the licensee failed to conduct employee evacuation drills at a frequency of every other month evident by a review of completed fire drill logs. Employee fire drills were completed in February, March, June, and September 2024. Employee fire drills were completed in February, September, and December 2024. During an interview on December 9, 2024, at 2:15 p.m., ULP-B verified the frequency was not met for employee FSEP training and employee evacuation drills. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 830 SS=F	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements, except a facility with a licensed resident capacity	0 830		

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0 830	Continued From page 20 of six or fewer is exempt from rental licensing regulations imposed by any town, municipality, or county. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to follow applicable state and local laws, regulations, standards, ordinances, and codes related to smoking for three of four residents (R1, R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1, R2 and R3 were admitted on October 25, 2023, January 13, 2023, and October 25, 2023, respectively, and received direct care services from the licensee. On December 9, 2024, at 11:05 a.m., the engineering surveyor toured the facility with unlicensed personnel (ULP)-B, and observed R1, R2 and R3's bedrooms. The engineer observed R1's bedroom smelled of smoke and had a burnt cigarette on the floor. The engineer observed R2's bedroom had burn marks on the floor, the bedding, and on the windowsill. The engineer further observed extinguished cigarettes in an ashtray on the floor of R3's bedroom.	0 830		

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0 830	Continued From page 21 On December 9, 2024, at 2:30 p.m., (ULP)-B stated he was aware the residents were smoking in their rooms but was unsure how to keep them from doing so, since they kept their bedroom doors locked. ULP-B further stated the licensee did have a designated smoking area. The Minnesota Department of Health's Minnesota Clean Indoor Air Act (MCIAA) amendment effective on August 1, 2019, noted smoking was prohibited in health care facilities and clinics. In addition, an indoor area meant a space between a floor and a ceiling that is at least half enclosed by walls, doorways, or windows (opened or closed) around the perimeter. A wall included retractable dividers, garage doors, plastic sheeting or any other temporary or permanent physical barrier. Minnesota State Statute 144.414 Prohibitions; Subdivision 3 dated 2022, indicated under a section titled Health care facilities and clinics: (a) Smoking is prohibited in any area of a hospital, health care clinic, doctor's office, licensed residential facility for children, or other health care-related facility, except that a patient or resident in a nursing home, boarding care facility, or licensed residential facility for adults may smoke in a designated separate, enclosed room maintained in accordance with applicable state and federal laws. The licensee's 4.59 Smoking/Tobacco Use policy, dated August 1, 2021, indicated "residents are prohibited smoking, using tobacco in any other form, or using cigar in the rooms, kitchen, bathroom and common area." No further information was provided.	0 830		

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0 830	Continued From page 22 TIME PERIOD FOR CORRECTION: Two (2) days	0 830		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure.	01470		

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01470	Continued From page 23 (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. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure employees received orientation to include all required content for one of two employees (registered nurse (RN)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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	01470		

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01470	Continued From page 24 the residents). The findings include: RN-A was hired February 17, 2023, to supervise staff and provide direct care services for the licensee's residents. On December 9, 2024, to December 11, 2024, during the survey period, RN-A was observed providing supervision to the licensee's staff and performing managerial duties. RN-A's employee record lacked documentation the following orientation topics were completed prior to providing assisted living services: -an overview of the appropriate Assisted Living statutes 144G and rules; -consumer advocacy services; and -principles of person-centered planning/service delivery. On December 11, 2024, at 9:50 a.m., RN-A stated she thought she had completed all the required content for orientation but must have missed it. The licensee's 5.01 Orientation of Staff and Supervisors & Content policy, dated 2021, indicated orientation topics would include the above required content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01500 SS=F	144G.63 Subd. 5 Required annual training	01500		

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01500	Continued From page 25 (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. Any training on hearing loss provided under this subdivision must be high quality and research	01500		

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01500	Continued From page 26 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: ULP-C was hired October 30, 2020, to provide direct care services. On December 11, 2024, at 8:00 a.m., ULP-C was	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35989	A. BUILDING: _____ B. WING _____	12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZUBEER GROUP HOME LLC	1567 COUNTY ROAD I ARDEN HILLS, MN 55126

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01500	Continued From page 27 observed to assist R2 with medication administration. ULP-C's employee record lacked evidence the employee had successfully completed at least eight hours of annual training for every 12 months of employment as required under 144G.63, Subd.5, to include the following: -infection control techniques. On December 11, 2024, at 9:50 a.m., RN-A stated ULP-C had been assigned the training but did not complete it. RN-A further stated she would need to start monitoring to ensure the trainings were completed on time The licensee's 5.06 Annual Required Staff Training policy, dated 2021, indicated annual training would include all the required topics as required under 144G.63, Subd.5. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01620	Continued From page 28 individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted ongoing resident monitoring and reassessment 14 calendar days from the initiation of services for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 was admitted January 13, 2023, and received services including assistance with housekeeping, behavior management and medication management.	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35989	A. BUILDING: _____ B. WING _____	12/11/2024

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ZUBEER GROUP HOME LLC	1567 COUNTY ROAD I ARDEN HILLS, MN 55126

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01620	Continued From page 29 On December 11, 2024, at 8:00 a.m., unlicensed personnel (ULP)-C was observed to assist R2 with medication administration. R2's record included an initial comprehensive nursing assessment, dated January 13, 2023, and a subsequent RN reassessment, dated January 31, 2023, completed 18 days (greater than 14 days) after the date services were initiated. On December 10, 2024, at 1:30 p.m., registered nurse (RN)-A stated R2's 14-day assessment was completed late because the residents' are sometimes hard to get to cooperate. RN-A further stated it had not been her process to document attempts to conduct an assessment or a resident's refusal of an assessment. The licensee's 6.01 Assessments, Reviews & Monitoring policy, dated August 1, 2021, indicated the RN would conduct a monitoring and reassessment no more than 14 days after the initiation of assisted living services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35989	A. BUILDING: _____ B. WING _____	12/11/2024

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01640	Continued From page 30 agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a current written service plan included a signature or other authentication by the facility and the resident documenting agreement on the services to be provided for one of three residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R3's current service plan, dated November 1, 2024, indicated R3 received services to include	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01640	Continued From page 31 medication management, behavior management, grooming and housekeeping. The service plan was signed by a facility representative, but lacked a signature or other authentication by the resident or resident's representative. On December 9, 2024, at 12:00 p.m., unlicensed personnel (ULP)-C was observed to assist R3 with medication administration. On December 10, 2024, at 10:15 a.m., registered nurse (RN)-A stated the licensee did not get a signature on R3's service plan. RN-A further stated the resident would sometimes refuse to sign paperwork, but they had not documented an attempt to get a signature or the resident's refusal to sign. The licensee's 6.08 Service Plan policy dated August 1, 2021, indicated the service plan and any revisions would include a signature or other authentication by the licensee. and by the resident, or resident's representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		

Type: Full
Date: *12/10/24*
Time: 13:08:11
Report: 1036241287

Food and Beverage Establishment Inspection Report

Location:

Zubeer Group Home Llc
1567 County Road I
Shoreview, MN55126
Ramsey County, 62

Establishment Info:

ID #: 0039159
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6197630751
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

3-500B Microbial Control: hot and cold holding

3-501.16A2 ***** Priority 1 *****

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

TCS ITEMS IN THE FRIDGE WERE FOUND TO BE OVER 41 DEGREES F. TCS ITEMS DISCARDED ON SITE. FRIDE TEMPERATURE GAUGE WAS TURNED DOWN TO PROPER AMBIENT TEMP.

Comply By: 12/10/24

4-600 Cleaning Equipment and Utensils

4-601.11A ***** Priority 2 *****

MN Rule 4626.0840A Equipment food-contact surfaces and utensils must be clean to sight and touch.

OBSERVED A DIRTY SPOON AND KNIFE WITH FOOD RESIDUE STORED IN DRAWER. UTENSILS WERE PUT IN DISH MACHINE. ISSUE CORRECTED ON SITE.

Comply By: 12/10/24

3-300B Protection from Contamination: cross-contamination, eggs

3-302.12

MN Rule 4626.0240 Properly label all working containers holding food or food ingredients that are removed from orginal packages with the common name of the food. Label the food in English and any other languages used by employees who handle food.

OBSERVED A CONTAINER OF SUGAR WITH NO CONTENT LABEL. ISSUE CORRECTED ON SITE.

Comply By: 12/10/24

Type: Full
Date: *12/10/24*
Time: 13:08:11
Report: 1036241287
Zubeer Group Home Llc

Food and Beverage Establishment Inspection Report

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.

OBSERVED SOME DAMAGED WALLS IN THE KITCHEN ENTRYWAY AND SOME DAMAGED CUPBOARDS. REPAIR AND MAINTAIN.

Comply By: 01/10/25

Surface and Equipment Sanitizers

Hot Water: = at 180 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/MILK
Temperature: 49 Degrees Fahrenheit - Location: FRIGIDARE COOLER
Violation Issued: Yes

Process/Item: Cold Hold/HOT DOGS
Temperature: 48 Degrees Fahrenheit - Location: FRIGIDARE COOLER
Violation Issued: Yes

Process/Item: Cold Hold/BUTTER
Temperature: 48 Degrees Fahrenheit - Location: FRIGIDARE COOLER
Violation Issued: Yes

Process/Item: Ambient Temp
Temperature: 46 Degrees Fahrenheit - Location: FRIGIDARE COOLER
Violation Issued: Yes

Process/Item: Ambient Temp
Temperature: 37 Degrees Fahrenheit - Location: FRIGIDARE COOLER (ADJUSTED)
Violation Issued: No

Process/Item: Ambient Temp
Temperature: 0 Degrees Fahrenheit - Location: FRIGIDARE COOLER
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	1	1	2

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. SURVEYOR FROM HRD WAS TAMMY CARLSON. INSPECTION CONDUCTED IN PRESENCE OF HAMDA FARAH, THE PERSON IN CHARGE. AT TIME OF INSPECTION, ESTABLISHMENT HAD 4 RESIDENTS. ALL VIOLATIONS WERE DISCUSSED WITH THE SURVEYOR AND PERSON IN CHARGE DURING INSPECTION.

THIS FACILITY DOES NOT HAVE COMMERCIAL GRADE ANSI EQUIPMENT. ALL FOOD MUST BE SERVED THE SAME DAY IT IS PREPARED, AND LEFTOVERS CAN NEVER BE SAVED.

FOOD SERVICE AREA FLOORS, WALLS, CEILINGS, COUNTERTOPS, AND FINISH MATERIALS MUST BE NON-ABSORBANT, SMOOTH, DURABLE, AND EASILY CLEANABLE. CEILINGS CANNOT HAVE POPCORN TEXTURE. CABINETS CANNOT HAVE HOLLOW BASES. EXPOSED WOOD IS NOT APPROVED FOR FOOD SERVICE AREAS. WOOD IS NOT AN APPROVED FOOD CONTACT SURFACE.

ADDITIONAL TOPICS DISCUSSED WITH THE PERSON IN CHARGE:
- EMPLOYEE ILLNESS LOG AND EXCLUSION POLICY.
- HAND WASHING POLICY AND REVIEW.
- GLOVE USAGE.
- NO BHC WITH RTE FOODS.
- THERMOMETER USE AND CALIBRATION.
- DATE MARKING TCS FOODS.
- PEST CONTROL.
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS.
- ANSI 184 STANDARD FOR RESIDENTIAL DISH WASHER.

FOR CORRECT BY DATES REFER TO COMPLETE REPORT ISSUED BY HRD.

**IF ANY RESIDENT COMPLAINS OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE CUSTOMER. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the inspection report number 1036241287 of 12/10/24.

Certified Food Protection Manager: ABDIAZIZ M. ISMAIL

Certification Number: FM116961 Expires: 04/26/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
HAMDA FARAH
PERSON IN CHARGE

Signed: _____
Jeff Johanson