Electronically Delivered

April 1, 2026

Licensee
Dis-Generation Group Inc
6825 46th Avenue North
Brooklyn Center, MN 55428

RE: Project Number(s) SL34602016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 3, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement;
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00

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

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

The correction order documentation should include the following:

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

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

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

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

factor.

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

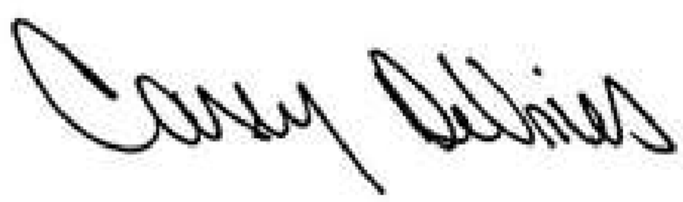
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Email: Casey.DeVries@state.mn.us
Telephone: 651-201-5917 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
	34602	A. BUILDING: _____ B. WING _____	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIS-GENERATION GROUP INC	6825 46TH AVENUE NORTH BROOKLYN CENTER, MN 55428

(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: SL34602016-0 On March 2, 2026, through March 3, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were three residents all of whom received services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated March 2, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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0 480	Continued From page 3 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for three of three residents (R1, R3, R4). 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:	0 630		

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0 630	Continued From page 4 R1 R1 was admitted to the licensee on November 5, 2025, and began receiving assisted living services. R1's diagnoses included attention deficit hyperactivity disorder (ADHD), traumatic brain injury, dysphagia (difficulty swallowing), and asthma. R1's Service Plan (EW) signed December 3, 2025, indicated R1 needed assistance with activities, bathing reminders, grooming set up, housekeeping, laundry, meals, medication administration, safety checks, shopping, and socialization. R1's IAPP dated March 2, 2026, indicated R1 was physically aggressive, sexually inappropriate, and verbally aggressive. In addition, R1 was at risk to be abused either physically, verbally, emotionally, financially, and/or sexually.. The IAPP had had an area for documentation of specific measures in place to minimize the risk to R1, however, had the word "Emotionally" documented instead of specific measures. R1's IAPP lacked the following required content: - the person's risk to abuse other vulnerable adults; and - statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. R3 R3 was admitted to the licensee on November 1, 2023, and began receiving assisted living services. R3's diagnoses included anxiety, anorexia nervosa, depression, diabetes, mild intellectual	0 630		

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0 630	Continued From page 5 disability, mood disorder, schizophrenia (mental disorder that affects how a person thinks, feels, and behaves often leading to hallucinations, delusions, and disorganized thinking), severe agitation, traumatic brain injury, and hypertension. R3's Service Plan (Waiver)- Addendum to Contract signed February 5, 2024, indicated R3 needed assistance with housekeeping, laundry, meals, medication administration, safety checks, shopping, and socialization. R3's IAPP dated February 4, 2026, indicated R3 was at risk to abuse other vulnerable adults and could be physically and verbally aggressive and sexually inappropriate. The IAPP had an area for documentation of specific measures in place to minimize the risk however, only indicated, "Client can verbally abuse other resident or staff." In addition, under the behavior section it included the following statements under plan of action: - R3 showed physical aggression when staff ignore them; - R3 became verbally aggressive when someone stepped on their boundary; and - R3 liked to stay in their room. The statements did not include interventions staff could implement to decrease the risk of R3 abusing others. In addition, the IAPP lacked an individualized review or assessment of R3's susceptibility to be abused by another individual. R4 R4 was admitted to the licensee on May 5, 2025, and began receiving assisted living services. R4's diagnoses included intellectual disability, anxiety, attention deficit disorder (ADD), depression, psychotic disorder, polysubstance disorder.	0 630		

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0 630	Continued From page 6 R4's Service Plan (Waiver) -Addendum to Contract signed May 5, 2025, indicated R4 needed assistance with activities, drinking, housekeeping, laundry, meals, medication administration, safety checks, shopping, and socialization. R4's IAPP dated February 4, 2026, indicated R4 was at risk to be abused and was at risk to abuse others. The IAPP had an area for documentation of specific measures in place to minimize the risk however, only indicated the words "emotional" and "yes". R4's IAPP lacked statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. On March 3, 2026, at 9:49 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated R1 was at risk to abuse others. The surveyor inquired why R1's IAPP did not address this. LALD/CNS-C then opened the IAPP assessment on the computer and the surveyor observed the statement was not clicked on in the assessment. LALD/CNS-C then clicked on the statement in the computer system to correct the deficiency for R1. LALD/CNS-C stated R3 was not at risk to be abused. LALD/CNS-C then opened the assessment on the computer and the surveyor observed the statement was not clicked on in the assessment. LALD/CNS-C then clicked on the statement in the computer system to correct the deficiency for R3. The surveyor inquired why R4's record did not include statements to reduce the risk of abuse for R4. LALD/CNS-C again opened the assessment on the computer and began writing statements in the action section. Each time the surveyor asked LALD/CNS-C a question related to the deficient	0 630		

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0 630	Continued From page 7 practices noted, LALD/CNS-C stayed silent and only corrected the assessments in the computer in front of the surveyor. The licensee's 6.05 Individual Abuse Prevention Plan policy dated July 26, 2021, indicated the IAPP would contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including: - other vulnerable adults; - the person risk of abusing other vulnerable adults; and - statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced	0 640		

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0 640	Continued From page 8 by: Based on observation, interview, and record review the licensee failed to support protection and safety by not posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC). This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: On March 2, 2026, at 9:56 a.m., during a facility tour, the surveyor did not observe information or a reporting number for MAARC posted in the common areas of the facility. On March 2, 2026, at 11:26 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated they believed they had posted the MAARC information in the common area however, they were unable to locate it. LALD/CNS-C stated, "Sorry it is not here, but I have it on my phone." The licensee's 2.44 Vulnerable Adult Maltreatment - Prevention & Reporting policy dated July 26, 2021, indicated the licensee would post information and the reporting number for MAARC. No further information was provided.	0 640		

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0 640	Continued From page 9 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following 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 employee records included all required content for two of two employees (unlicensed personnel (ULP)-A, ULP-B).	0 650		

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0 650	Continued From page 10 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-A was hired on August 19, 2025, to provide assisted living services. ULP-B was hired on August 19, 2025, to provide assisted living services. ULP-A and ULP-B's employee record lacked training and record of a returned demonstration competency evaluation for medication set up for a resident's unplanned time away from home. R1's Med Amin Summary - Month dated February 2026, indicated ULP-A and ULP-B administered medication to R1 during the month of February. On March 3, 2026, at 9:36 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated residents at the facility have received medication to take with them for unplanned times away from the facility. LALD/CNS-C stated they train ULP on setting up medication for unplanned times away. LALD/CNS-C stated ULP were trained to fill in paperwork, provide medications to the family member, have the family member sign that they had received the medications, and then notify LALD/CNS-C. LALD/CNS-C stated ULP were trained during orientation and then unplanned	0 650		

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(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
0 650	Continued From page 11 time away was reviewed again during the ULP's 30-day supervision. LALD/CNS-C stated they completed a return demonstration with the ULP to make sure they did not need any additional support. LALD/CNS-C stated they did not have training documentation or competency evaluation documentation for unplanned time away from home for any ULP at the facility. On March 3, 2026, at 12:05 p.m., ULP-K stated they received training and completed a return demonstration for medication set up for unplanned time away. The licensee's Policy and Procedure for Unplanned Time Away from the Facility dated October 5, 2021, indicated staff would put the set-up medication into the small clear bag and place it in the brown envelope with instructions showing when to take the medications. The policy did not address staff training or competency requirements. The licensee's 4.05 Employee Records policy dated July 26, 2021, indicated the employee record would include records of all training and in-service education required and/or provided including record of competency testing as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a	0 660		

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	34602	A. BUILDING: _____ B. WING _____	03/03/2026

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0 660	Continued From page 12 comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), including a TB facility risk assessment and a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test for one of two employees (unlicensed personnel (ULP)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 660		

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0 660	Continued From page 13 The licensee's Facility TB Risk Assessment Worksheet for Health Care Setting Licensed by MDH dated February 20, 2026, page 11, was not filled in by the licensee. The page included information regarding who maintained TB records, where TB records were stored, annual conversion rate, TB risk level, name of person responsible for TB infection control in facility, if TB testing was required for residents, and if annual screening needed to be conducted. ULP-A was hired by the licensee on August 19, 2025, to provide assisted living services. ULP-A's record included a TB health history screen completed April 2, 2025, first step TST completed April 2, 2025, and a second step TST completed April 14, 2025. ULP-A's record lacked evidence of TB screening completed within 90 days of being hired by the licensee. On March 3, 2026, at 10:01 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated newly hired employees completed a blood draw to test for TB and if the results were positive for TB they would complete a chest Xray. LALD/CNS-C stated they accepted TST results completed within 90 days of being hired and QuantiFERON gold results completed within one year of hire of being hired. The surveyor inquired why ULP-A's TSTs were accepted when they were not completed within 90 days of hire. LALD/CNS-C stated they did not know ULP-A completed a two-step TST and it was their error. LALD/CNS-C stated they did not know why the TB facility risk assessment was not completed fully completed. The CDC's document titled Baseline Tuberculosis Screening and Testing for Health Care Personnel	0 660		

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0 660	Continued From page 14 dated December 19, 2023, recommended all health care personnel should be screened for TB upon hire and the TB screening process included: - a baseline individual TB risk assessment; - TB symptom evaluation; - a TB test which could include TB blood test or TB skin test; and - additional evaluation for TB disease as needed. The Minnesota Department of Health (MDH) Resources and Frequently Asked Questions (FAQs) dated October 13, 2025, indicated TST or interferon-gamma release assays (IGRAs) could be accepted as an acceptable TB screen if it was dated within 90 days of being hired. In addition, providers were required to complete a TB risk assessment annually. Completion of the TB facility risk assessment would assist providers in the development of an infection control committee and determine the frequency of screening. The licensee's 8.16 Tuberculosis Screening policy dated July 26, 2021, indicated the facility would maintain a current community TB risk assessment. In addition, employees whose essential job functions required work within the same air space of the residents would be screened and tested for tuberculosis prior to the staff being exposed to the residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680		

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0 680	Continued From page 15 (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 maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when	0 680		

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0 680	Continued From page 16 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 Preparedness Program last reviewed August 23, 2025, lacked evidence of the following required content: - hazard vulnerability risk assessment; - quarterly review of the missing resident plan; - sewage and waste disposal; - emergency officials contact information which included the Minnesota Office of Ombudsman for Long Term Care (OOLTC); and - emergency prep testing requirements. On March 3, 2026, at 10:10 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated the licensee did not have a hazard vulnerability assessment. LALD/CNS-C stated they would evacuate the building if there were issues with sewage until the issue could be fixed, but that was not documented in writing. LALD/CNS-C stated the missing resident plan was reviewed annually or with an incident of elopement. LALD/CNS-C verified OOLTC phone number was not located in the EPP. The surveyor observed in the EPP binder empty logs of drills conducted. The surveyor requested drills conducted for the EPP. The surveyor did not receive the documents prior to the end of survey. The licensee's 9.01 Emergency Preparedness Plan - Appendix Z Compliance policy dated July 26, 2021, indicated the licensee had in place an effective and compliant EPP. The intent was the plan would be aligned with the Centers for Medicare and Medicaid Services State Operation Manual Appendix Z.	0 680		

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0 680	Continued From page 17 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated 3/3/2026, for the specific violations related the physical environment under Minnesota Statute 144G.	0 775		

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0 775	Continued From page 18 TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
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 19 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated 3/3/2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 810		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring	01290		

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01290	Continued From page 20 self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was affiliated with the assisted living licensee for two of two employees (unlicensed personnel (ULP)-A, ULP-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's health facility identification number (HFID#) was 34602. ULP-A ULP-A was hired on August 19, 2025, to provide assisted living services. ULP-A's personnel file included a background study affiliated with HFID# 33047 completed on	01290		

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01290	Continued From page 21 August 18, 2025. ULP-A's record lacked a background study affiliated with the licensee's HFID#. ULP-B ULP-B was hired on August 19, 2025, to provide assisted living services. ULP-B's personnel file included a background study affiliated with HFID# 37713 completed on October 8, 2025. ULP-B's record lacked a background study affiliated with the licensee's HFID#. On March 3, 2026, at 8:45 a.m., the surveyor compared the licensee's staff list to NetStudy 2.0 (a web-based system used to submit background study requests to the Department of Human Services) rosters that were received by licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C and observed the following: - ULP-F was affiliated to HFID# 37713; - secretary (s)-G affiliated to HFID# 33047; - ULP-H was affiliated to HFID# 33047; - ULP-I was affiliated to HFID# 33047; and - ULP-J was affiliated to HFID# 33047. On March 3, 2026, LALD/CNS-C stated background studies were completed by owner (O)-E. On March 3, 2026, at 9:42 a.m., O-E stated when a person was hired, they ran a background study and then updated LALD/CNS-C if the employee was required to have supervision or not while working with residents. O-E stated they had three different HFID#'s within the company and when an employee was hired, they were affiliated to the HFID# they most frequently worked at.	01290		

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01290	Continued From page 22 The licensee's 4.02 Background Studies policy dated July 26, 2021, indicated no employee may provide direct services and have independent contact with any resident until acceptable result of the background study have been received. The policy did not address affiliating the background studies to the licensee's HFID#. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's	01620		

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01620	Continued From page 23 needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed an assessment that did not exceed 14 days from day of admission for two of two residents (R1, R4) and failed to ensure ongoing resident assessments did not exceed 90 days for two of three residents (R1, 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	01620		

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01620	Continued From page 24 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: R1 R1 was admitted to the licensee on November 5, 2025, and began receiving assisted living services. R1's diagnoses included attention deficit hyperactivity disorder (ADHD), traumatic brain injury, dysphagia (difficulty swallowing), and asthma. R1's Service Plan (EW) signed December 3, 2025, indicated R1 needed assistance with activities, bathing reminders, grooming set up, housekeeping, laundry, meals, medication administration, safety checks, shopping, and socialization. R1's record included a 14-day assessment completed on November 24, 2025, and an ongoing assessment completed during the survey on March 2, 2026, which indicated the 14-day assessment was completed 19 days after admission and the ongoing assessment was completed 98 days after the assessment completed on November 24, 2025. R3 R3 was admitted to the licensee on November 1, 2023, and began receiving assisted living services. R3's diagnoses included anxiety, anorexia	01620		

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01620	Continued From page 25 nervosa, depression, diabetes, mild intellectual disability, mood disorder, schizophrenia (mental disorder that affects how a person thinks, feels, and behaves often leading to hallucinations, delusions, and disorganized thinking), severe agitation, traumatic brain injury, and hypertension. R3's Service Plan (Waiver)- Addendum to Contract signed February 5, 2024, indicated R3 needed assistance with housekeeping, laundry, meals, medication administration, safety checks, shopping, and socialization. R3's record included ongoing assessments dated October 28, 2025, and February 4, 2026, which indicated 100 days passed between the October 28, 2025, assessment and the February 4, 2026, assessment. R4 R4 was admitted to the licensee on May 5, 2025, and began receiving assisted living services. R4's diagnoses included intellectual disability, anxiety, attention deficit disorder (ADD), depression, psychotic disorder, and polysubstance disorder. R4's Service Plan (Waiver) -Addendum to Contract signed May 5, 2025, indicated R4 needed assistance with activities, drinking, housekeeping, laundry, meals, medication administration, safety checks, shopping, and socialization. R4's record included an admission assessment completed May 5, 2025, and a 14-day assessment completed on August 5, 2025, which indicated the licensee did not conduct a 14-day assessment and the next assessment was	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34602	A. BUILDING: _____ B. WING _____	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIS-GENERATION GROUP INC	6825 46TH AVENUE NORTH BROOKLYN CENTER, MN 55428

(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
01620	Continued From page 26 completed 92 days after admission. On March 3, 2026, at 10:30 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated R1's ongoing assessment was late because they forgot to lock the assessment in the computer, and they were unsure why R1's 14-day assessment was late. The surveyor inquired why R3's assessment was late. LALD/CNS-C asked if the assessment was due on a weekend and then stated, "sometimes I do it when I come in on Monday." LALD/CNS-C stated they believed they completed R4's 14-day assessment on paper, and they did not have enough information to complete the assessment which delayed the assessment. The licensee's undated 6.01 Assessment, Reviews & Monitoring policy indicated resident's reassessment and monitoring must be conducted no more than 14 calendar days after the initiation of services. In addition, ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 days from the last date of the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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DIS-GENERATION GROUP INC	6825 46TH AVENUE NORTH BROOKLYN CENTER, MN 55428

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01730	Continued From page 27 must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management.	01730		

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DIS-GENERATION GROUP INC	6825 46TH AVENUE NORTH BROOKLYN CENTER, MN 55428

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01730	Continued From page 28 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a current individualized medication management record for each resident to include all required content for three of three residents (R1, R3, R4). 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: R1 R1 was admitted to the licensee on November 5, 2025, and began receiving assisted living services. R1's diagnoses included attention deficit hyperactivity disorder (ADHD), traumatic brain injury, dysphagia (difficulty swallowing), and asthma. R1's Service Plan (EW) signed December 3, 2025, indicated R1 needed assistance with activities, bathing reminders, grooming set up, housekeeping, laundry, meals, medication administration, safety checks, shopping, and socialization. R1's Individualized Medication Management Plan dated March 2, 2026, indicated R1 was unable to	01730		

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	34602	A. BUILDING: _____ B. WING _____	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIS-GENERATION GROUP INC	6825 46TH AVENUE NORTH BROOKLYN CENTER, MN 55428

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01730	Continued From page 29 administer their own medications, medications were secured, unlicensed personnel (ULP) could administer R1's inhaler, and staff should contact the licensed nurse by phone if there were questions or concerns. R1's individual medication management plan lacked identification of persons responsible for monitoring supplies and ensuring that medication refills were ordered on a timely basis. R3 R3 was admitted to the licensee on November 1, 2023, and began receiving assisted living services. R3's diagnoses included anxiety, anorexia nervosa, depression, diabetes, mild intellectual disability, mood disorder, schizophrenia (mental disorder that affects how a person thinks, feels, and behaves often leading to hallucinations, delusions, and disorganized thinking), severe agitation, traumatic brain injury, and hypertension. R3's Service Plan (Waiver)- Addendum to Contract signed February 5, 2024, indicated R3 needed assistance with housekeeping, laundry, meals, medication administration, safety checks, shopping, and socialization. R3's Individualized Medication Management Plan dated February 4, 2026, indicated R3 was able to state their medications and indications, medications were in a secured storage, ULP could administer R3's inhaler, and staff should contact the licensed nurse by phone if there were questions or concerns related to medications. R3's Med Amin Summary - Month dated March 2026 included nystatin 100,000 units/gram (u/g) apply one strip topically to affected area three	01730		

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	34602	A. BUILDING: _____ B. WING _____	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIS-GENERATION GROUP INC	6825 46TH AVENUE NORTH BROOKLYN CENTER, MN 55428

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01730	Continued From page 30 times daily and olanzapine 5 milligrams (mg) give one to two tablets by mouth two times per day as needed (PRN). The medication administration record (MAR) lacked specific instructions on where to apply nystatin and when to give one tablet verses two tablets of olanzapine. R3's individualized medication management plan comprised of multiple documents lacked the following: - identification of persons responsible for monitoring supplies and ensuring that medication refills were ordered on a timely basis; and - documentation of specific resident instructions relating to the administration of medication. R4 R4 was admitted to the licensee on May 5, 2025, and began receiving assisted living services. R4's diagnoses included intellectual disability, anxiety, attention deficit disorder (ADD), depression, psychotic disorder, and polysubstance disorder. R4's Service Plan (Waiver) -Addendum to Contract signed May 5, 2025, indicated R4 needed assistance with activities, drinking, housekeeping, laundry, meals, medication administration, safety checks, shopping, and socialization. R4's Individualized Medication Management Plan dated February 4, 2026, indicated staff administered R4's medications, medications were in a secure storage, ULP were delegated the administration of rectal medication, and staff should contact the licensed nurse by phone if there were questions or concerns related to medications. R4's individual medication	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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DIS-GENERATION GROUP INC	6825 46TH AVENUE NORTH BROOKLYN CENTER, MN 55428

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01730	Continued From page 31 management plan lacked identification of persons responsible for monitoring supplies and ensuring that medication refills were ordered on a timely basis. On March 3, 2026, at 10:36 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated they were responsible for medication refills, and they believed they documented that in R1, R3, and R4's individualized medication management plans. LALD/CNS-C then opened R3 assessment in the computer and the surveyor observed the box with the statement for the nurse completing refills was not clicked on in the assessment. The surveyor then observed LALD/CNS-C click the box. LALD/CNS-C stated R3 received one tablet of olanzapine when a PRN was provided because it kept R3's symptoms under control. LALD/CNS-C stated ULP called them when they needed to administer olanzapine and they would instruct ULP to administer one tablet. LALD/CNS-C verified nystatin lacked a location for application. LALD/CNS-C stated the nystatin should be applied to R3's groin. The licensee's 7.03 Medication Management Individualized Plan dated July 26, 2021, indicated the individualized medication management record for each resident based on the resident's assessment must contain documentation of specific resident instructions relating to the administration of medications and identification of person responsible for monitoring medication supplies and ensuring that medication refills were ordered on a timely basis. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01730	Continued From page 32 days	01730		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to discard expired medication 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: On March 2, 2026, at 10:08 a.m., the surveyor observed the licensee's locked medication closet and observed the following expired medications: - ammonium lactate cream 12 percent (%) with an expiration date of March 2025; - Nurtec 75 milligrams (mg) discard after February 25, 2026; and - MiraLAX with an expiration date of December 2025.	01890		

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01890	Continued From page 33 On March 2, 2026, at 11:26 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated they went through the medication closet monthly to look for medication that had expired. LALD/CNS-C stated if there were expired medications when they reviewed the medication closet, they would dispose of the medication into the sharp's container. LALD/CNS-C stated R3 no longer used ammonium lactate cream or MiraLAX. LALD/CNS-C stated the unlicensed personnel (ULP) were not using the medication so they did not notice they were expired. On March 2, 2026, at 12:11 p.m., during interview with LALD/CNS-C and registered nurse (RN)-D, RN-D showed the surveyor the box of Nurtec and stated that was the date they were using for the expiration date. The surveyor explained staff needed to use the expiration date listed on the pharmacy label not the box. RN-D stated they were unaware to use the prescription label for the expiration date. LALD/CNS-C stated they did not know that discard meant expired. The licensee's 7.23 Medication Disposal policy dated July 26, 2021, indicated shall dispose of any medication that were expired according to state and federal regulations for disposition of medication and controlled substances. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

DIS-Generation Group Inc
6825 46th Avenue North
Crystal, MN 55428
Hennepin County
Parcel:

Phone:

License Info

License: HFID 34602

Risk:
License:
Expires on:
CFPM: Stella Chidimma Iwuchukwu
CFPM #: 53414; Exp: 10/17/2027

Inspection Info

Report Number: F7994261043
Inspection Type: Full - Single
Date: 3/2/2026 Time: 11:37:52 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 1
Delivery: Emailed

New Order: 4-500 Equipment Maintenance and Operation
4-501.11AB *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.
COMMENT: Cabinet found missing door. Repair or replace missing door.
Comply By: 3/16/2026 Originally Issued On: 3/2/2026

Food & Beverage General Comment

INSPECTION CONDUCTED IN THE PRESENCE OF HRD STAFF AND FINDINGS SHARED AT THE END OF INSPECTION.

WILL EMAIL SUPPORTING DOCUMENTS AND LINKS TO HRD STAFF AT THE END OF THE DAY.

KITCHEN IS RESIDENTIAL AND FOOD IS PREPARED FOR SAME DAY SERVICE.

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 F7994261043 from 3/2/2026

Establishment Representative

Crystal Elva, REHS, MS, BS
Public Health Sanitarian 3
651-201-3981
crystal.elva@state.mn.us

Minnesota (MDH) Version
EH Manager; RPT: F7994261043

Food Establishment Inspection Report

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

No. of Risk Factor/Intervention/Violations	0	Date: 3/2/2026
No. of Repeat Risk Factor/Intervention/Violations		Time: 11:37:52 AM
Score (optional)		Dur: min

Establishment:	Address:	City/State:	Zip:	Phone:
DIS-Generation Group Inc	6825 46th Avenue North	Crystal, MN	55428	
License/Permit #:	**Permit Holder:**	**Purpose of Inspection:**	**Est. Type:**	**Risk Category:**
HFID 34602		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Designated compliance status (IN, OUT, N/O, N/A) for each numbered item

IN=in compliance **OUT**=not in compliance **N/O**=not observed **N/A**=not applicable

Mark "X" in appropriate box for COS and/or R

COS=corrected on-site during inspection **R**=repeat violation

	Compliance Status		COS	R
	Supervision			
1	IN	Person in charge present, demonstrate knowledge and performs duties		
2	IN	Certified Food Protection Manager		
	Employee Health			
3	IN	knowledge, responsibiities, and reporting		
4	IN	Proper use of restriction and exclusion		
5	IN	Response to vomiting, diarrheal events		
	Good Hygienic Practices			
6	IN	Proper eating, tasting, drinking, tobacco use		
7	IN	No discharge from eyes, nose, and mouth		
	Preventing Contamination by Hands			
8	IN	Hands clean and properly washed		
9	IN	No bare hand contact with RTE foods, alternatives		
10	IN	Adequate handwashing sinks supplied and access		
	Approved Source			
11	IN	Food obtained from approved source		
12	N/O	Food Received at proper temperature		
13	IN	Food in good condition, safe & unadulterated		
14	N/A	Records available: shellstock tags, parasite dest.		
	Protection From Contamination			
15	IN	Food separated and protected		
16	IN	Food-contact surfaces; cleaned & sanitized		
17	IN	Proper Disposition of returned, previously served, reconditioned,& unsafe food		

	Compliance Status		COS	R
	Time/Temperature Control for Safety			
18	N/O	Proper cooking time & temperatures		
19	N/A	Proper reheating procedures for hot holding		
20	N/A	Proper cooling time and temperature		
21	N/A	Proper hot holding temperatures		
22	IN	Proper cold holding temperatures		
23	IN	Proper date marking & disposition		
24	N/A	Time as public health control;procedures & record		
	Consumer Advisory			
25	N/A	Consumer advisory provided for raw or undercooked foods		
	Highly Susceptible Populations			
26	N/A	Pasteurized foods used; prohibited foods not offered		
	Food/Color Additives and Toxic Substances			
27	N/A	Food additives; approved & properly used		
28	IN	Toxic substances properly identified;stored;used		
	Conformance with Approved Procedures			
29	N/A	Compliance with variance, specialized processes & HACCP plan		

Risk factors are improper practices or procedures identified as the most prevalent contributing factors of foodborne illness or injury. Public Health Interventions are control measures to prevent foodborne illness or injury

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" or OUT in box if numbered item is **not** in compliance Mark "X" in appropriate box for COS and/or R **COS**=corrected on-site during inspection **R**=repeat violation

			COS	R
		Safe Food and Water		
30	N/A	Pasteurized eggs used where required		
31		Water & ice from approved source		
32	N/A	Variance obtained for specialized processing methods		
		Food Temperature Control		
33		Proper cooling methods used; adequate equipment for temperature control		
34	N/A	Plant food properly cooked for hot holding		
35	IN	Approved thawing methods used		
36		Thermometers provided & accurate		
		Food Identification		
37		Food properly labeled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present; no unauthorized person		
39		Contamination prevented during food prep, storage, & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
		Proper Use of Utensils		
43		In-use utensils; Properly stored		
44		Utensils, equipment & linens; properly stored, dried, handled		
45		Single-use & single-service articles, properly stored and used		
46		Gloves used properly		
		Utensils, Equipment and Vending		
47	X	Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, used; test strips		
49		Non-food contact surfaces clean		
		Physical Facilities		
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities; properly constructed, supplied & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing and plan review		

Person in Charge (signature)

Inspector (signature) Crystal Elva

Follow-up: Follow-up Date:

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL34602016-0	**Date:** 3/3/2026
Facility Name: Dis-Generation Group INC	
Facility Address: 6825 46th Ave N Minneapolis, MN 55428	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]

2. Lighted matches, cigarettes, cigars or other burning object shall not be discarded in such a manner that could cause ignition of other combustible material. [Minn. Stat. 144G.45 subd. 2; MSFC 310.7]

   Comments: During the survey, evidence of smoking was observed in Resident Room 2. The windowsill had burn marks, and immediately outside the window on the exterior, discarded cigarette butts and ash were present. Discarded cigarette butts were also observed outside the facility, adjacent to the kitchen door.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

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

   Comments: Licensee Fire Safety and Evacuation Plan (FSEP) failed to include site-specific employee actions relative to the facility's building layout, evacuation routes, and ways to remove residents. Staff responsibilities and evacuation procedures were not clearly defined.

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

   Comments: Documentation of staff training on the FSEP was not provided by the licensed assisted living director/clinical curse supervisor (LALD/CNS)-A upon request.

3. Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. [Minn. Stat. 144G.45 subd.2]

   Comments: Review of fire drill records provided by LALD/CNS-A showed two fire drills conducted during calendar year 2025. The documentation did not indicate that fire drills were conducted on each shift or the minimum number of annual drills.