Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 4, 2025

Licensee
Adequate Home Care LLC
10255 Madison Street Northeast
Blaine, MN 55434

RE: Project Number(s) SL39370016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 4, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

The correction order documentation should include the following:

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

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

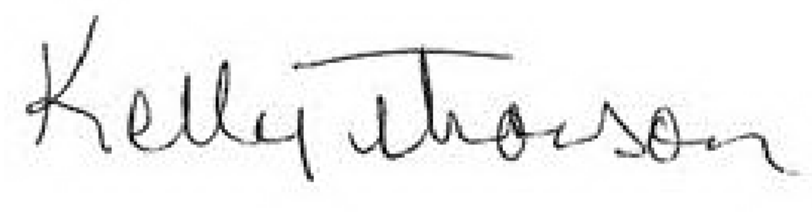
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

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

If you have any questions, please contact me.

Sincerely,



Kelly Thorson, Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

AH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39370	A. BUILDING: _____ B. WING _____	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADEQUATE HOME CARE LLC	10255 MADISON STREET NORTHEAST BLAINE, MN 55434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ***ATTENTION*** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#39370016 On June 2, 2025, through June 4, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 2 residents; 2 receiving 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated June 2, 2025, 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		
0 780 SS=E	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide interconnected smoke alarms	0 780		

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0 780	Continued From page 4 that complied with fire protection requirements. 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On June 4, 2025, at 10:45 a.m., the surveyor toured the facility with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A. During the facility tour, the surveyor observed when LALD/CNS-A tested the smoke alarms, the smoke alarms in sleeping rooms 1 and 3 were not actuated. During the facility tour interview on June 4, 2025, LALD/CNS-A verified the smoke alarms were not testing as interconnected and stated there was a problem with the settings. Additionally, the smoke alarm in the mechanical room was not actuated when the other dwelling unit smoke alarms were tested by LALD/CNS-A. LALD/CNS-A verified this battery operated smoke alarm was not interconnected and stated the mechanical room smoke alarm was not included in the project when the other dwelling unit smoke alarms were interconnected. All dwelling unit smoke alarms must be interconnected so actuation of one alarm causes all alarms in the dwelling unit to operate. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		

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0 800	Continued From page 5	0 800		
0 800 SS=E	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On June 4, 2025, at 10:45 a.m., the surveyor toured the facility with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A. During the facility tour, the surveyor observed the	0 800		

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0 800	Continued From page 6 following: - In unoccupied resident sleeping room 4, two electrical wall outlets were loose and the window sill surface was rough and water damaged. - In occupied resident sleeping room 2, the carpet was soiled and stained. - The railings and floor surface of the exterior deck were peeling and the surfaces rough. One of the railings had a hole in the top where the wood had deteriorated. During the facility tour interview on June 4, 2025, LALD/CNS-A verified the above listed physical environment observations and stated these items would be corrected. 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.	0 810		

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0 810	Continued From page 7 (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with required content, make all parts of the plan readily available, 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 June 4, 2025, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the	0 810		

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0 810	Continued From page 8 facility. FIRE SAFETY AND EVACUATION PLAN On June 4, 2025, at 10:45 a.m., the surveyor toured the facility with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A. During the facility tour, the surveyor observed copies of the fire safety and evacuation plan were posted in the kitchen and stored in the emergency preparedness binder. Record review of the available documentation indicated the individualized unique procedures for residents requiring assistance in the event of an evacuation were not located in a central location for all staff accessibility. During an interview on June 4, 2025, at 12:15 p.m., LALD/CNS-A stated this part of the plan was stored electronically on the computer and verified a printed copy for the FSEP was not maintained as readily available. On June 4, 2025, at 10:45 a.m., the surveyor toured the facility with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A. During the facility tour, LALD/CNS-A verbally identified resident sleeping rooms as 1, 2, 3, and 4. Number identifiers were not posted at the sleeping room doors. The licensee failed to identify the location of resident sleeping rooms. Resident sleeping room identifiers are required to be installed at the resident room doors and correspond with the number labels on the fire safety and evacuation floor plan to provide efficient communication for exiting in the event of a fire or similar emergency. On June 4, 2025, at 10:45 a.m., the surveyor toured the facility with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A. During the facility tour, the surveyor observed an exit sign was posted at the front door. The emergency evacuation floor plan dated April 12, 2000, failed to label the main exit for the building. Exit labels are required to be included on the floor	0 810		

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0 810	Continued From page 9 plan and correspond with the exit signs posted in the building. FSEP floor plans shall be easy to read and readily understandable by the building occupants in the event of an emergency. Record review of the available documentation indicated the licensee failed to develop a FSEP with procedures specific to the assisted living facility and the building occupants evident by the following: - The FSEP dated July 22, 2024, was a template from a third party provider. - 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. - Pull fire alarms were inaccurately referenced. - The FSEP included standard resident evacuation procedures but failed to provide site specific procedures for resident movement and evacuation during a fire or similar emergency - The FSEP failed to include site specific fire protection instructions for residents evident by no procedures in the plan. During an interview on June 4, 2025, at 12:20 p.m., LALD/CNS-A verified the FSEP required revision. TRAINING Record review indicated the licensee failed to provide fire safety and evacuation training to residents at least once per year evident by a lack of documentation to support this training had been completed. During an interview on June 4, 2025, at 12:20 p.m., LALD/CNS-A stated resident initials were recorded on the FSEP posted in the kitchen when this training was completed. Resident training records lacked the dates and names of the participants.	0 810		

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0 810	Continued From page 10 Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and at least twice per year evident by the lack of documentation to support this training had been completed. Emergency preparedness employee training records dated May 21, 2024, and June 7, 2024, were provided. These records did not list the site specific FSEP as part of the training. An emergency preparedness training from an online learning platform dated May 2025 was provided. This employee training did not include the site specific FSEP. During an interview on June 4, 2025, at 12:20 p.m., LALD/CNS-A verified the training records were lacking and stated they were not aware employee FSEP training was required twice per year. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month evident by a review of a fire drill audit dated June 1, 2024, to June 3, 2025. The following six fire drills were recorded during this time period: August, 5, 2024 at 7:30 a.m. October 12, 2024 at 9:15 p.m. October 19, 2024 at 10:15 p.m. January 14, 2025 at 2:45 p.m. March 7, 2025 at 7:15 p.m. May 28, 2025 at 9:15 p.m. During an interview on June 4, 2025, at 12:20 p.m., LALD/CNS-A verified the evacuation fire drill frequency was not met. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		

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01060	Continued From page 11	01060		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not	01060		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39370	A. BUILDING: _____ B. WING _____	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADEQUATE HOME CARE LLC	10255 MADISON STREET NORTHEAST BLAINE, MN 55434

(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
01060	Continued From page 12 returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but hat 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 residents). The findings include: R1 was admitted to the licensee and started receiving assisted living services on July 11, 2020. R1's record indicated R1 was admitted to the hospital on February 19, 2025. Following the hospitalization, R1 transferred to a transitional care unit (TCU) for rehabilitation services. R1 returned to the licensee on March 5, 2025. R1's record lacked a written notice including: -the name and contact information for the location to which the resident has been relocated and any new service provider	01060		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39370	A. BUILDING: _____ B. WING _____	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADEQUATE HOME CARE LLC	10255 MADISON STREET NORTHEAST BLAINE, MN 55434

(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
01060	Continued From page 13 -contact information for the Office of Ombudsman for Long-Term Care -if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known -a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. R1's record lacked notification to the Office of Ombudsman for Long-Term Care that the resident had been relocated and had not returned to the facility within four (4) days. On June 4, 2025, at 12:33 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated he was not aware of the requirement and had not completed emergency notifications for any resident. The licensee's Discharge and Transfer of Residents policy dated February 1, 2021, indicated in the event of an emergency relocation, the facility will, as soon as possible, provide written notice of Emergency Relocation to the following: the resident, the resident's legal representatives, the resident's designated representatives, the resident's case manager and if the resident has been relocated and not returned to the facility within four days, the Office of Ombudsman for Long-Term Care. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01060		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39370	A. BUILDING: _____ B. WING _____	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADEQUATE HOME CARE LLC	10255 MADISON STREET NORTHEAST BLAINE, MN 55434

(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
01530 SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39370	A. BUILDING: _____ B. WING _____	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADEQUATE HOME CARE LLC	10255 MADISON STREET NORTHEAST BLAINE, MN 55434

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01530	Continued From page 15 for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received eight hours of initial dementia care training within the first 160 hours worked for one of one employee (unlicensed personnel (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) 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: During the entrance conference on June 2, 2025, at 10:45 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee was aware of the required contents of the employee record. ULP-B began employment on May 21, 2024, to provide direct care services to residents. ULP-B's orientation and training record lacked documentation of the required number of hours of dementia care training. The training record dated June 7, 2024, included: -Dementia- Activities, A Balanced Approach .75 -Dementia - Communication 1.25 -Dementia - Problem Solving .75	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39370	A. BUILDING: _____ B. WING _____	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADEQUATE HOME CARE LLC	10255 MADISON STREET NORTHEAST BLAINE, MN 55434

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01530	Continued From page 16 On August 4, 2025, at 12:21 p.m., LALD/CNS-A stated all ULP's received four (4) hours of initial dementia training, he was not aware of the eight (8) hour requirement. In addition, LALD/CNS-A stated he was not aware that ULP-B only had 2.5 hours of initial dementia training in the employee record and does not know why it was not completed. The licensee's Dementia Education policy dated August 1, 2021, indicated direct care employees will complete eight (8) hours of initial training within 160 hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		

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

Adequate Home Care LLC
10255 Madison Street NE
Blaine, MN 55434
Anoka County
Parcel:

Phone:

License Info

License: HFID 39370

Risk:
License:
Expires on:
CFPM: MOUNIR AYOUB
CFPM #: 45546; Exp: 5/28/2028

Inspection Info

Report Number: F1029251019
Inspection Type: Full - Single
Date: 6/2/2025 Time: 3:34:05 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 2
Total Priority 2 Orders: 1
Total Priority 3 Orders: 1
Delivery:

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

3-302.11A(1) *Priority Level: Priority 1 CFP#: 15*

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

COMMENT: UNPASTEURIZED SHELL EGGS ABOVE, AND NOT SUFFICIENTLY SEPARATED, FROM READY-TO-EAT FOODS. OPERATOR INSTRUCTED TO EFFECTIVELY PROTECT RTE FOODS FROM RAW ANIMAL PROTEINS BY KEEPING ON A LOWER LEVEL AND/OR BY PROVIDING A BARRIER MAKING IT IMPOSSIBLE FOR CROSS-CONTAMINATION TO OCCUR.

Comply By: 6/2/2025 Originally Issued On: 6/2/2025

! New Order: 3-500B Microbial Control: hot and cold holding

3-501.16A2 *Priority Level: Priority 1 CFP#: 22*

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

COMMENT: SEVERAL TCS ITEMS IN COOLER IN DANGER ZONE DISCARDED BY OPERATOR. OPERATOR INSTRUCTED TO NOT PLACE ANY ADDITIONAL TCS ITEMS INTO COOLER UNTIL SAFE HOLDING TEMPERATURES ARE VERIFIED.

Comply By: 6/2/2025 Originally Issued On: 6/2/2025

New Order: 3-500C Microbial Control: date marking

3-501.17B *Priority Level: Priority 2 CFP#: 23*

MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.

COMMENT: OPENED BAGS OF SLICED DELI MEAT AND SHREDDED CHEESE WITH OUT DATE MARKINGS. OPERATOR INSTRUCTED TO DATE MARK REQUIRED ITEMS. DATE MARKING PRACTICES REVIEWED WITH OPERATOR DURING INSPECTION.

Comply By: 6/2/2025 Originally Issued On: 6/2/2025

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: REFRIGERATOR NOT MAINTAINING SAFE HOLDING TEMPERATURES THROUGHOUT. COOLER SET TO 7 OUT 9 WITH 9 BEING THE COLDEST SETTING. OPERATOR ADJUSTED COOLER TO 8. INTERNAL THERMOMETER MOVED FROM TOP REAR OF CAVITY TO MIDDLE FRONT OF CAVITY. A CUP WITH WATER WAS ALSO PLACED INTO THE COOLER AND THE OPERATOR WAS INSTRUCTED TO USE THE SMALL DIAMETER PROBE THERMOMETER TO TEST THE WATER TO VERIFY SAFE TEMPERATURES AND TO CORROBORATE THE ACCURACY OF THE INDEPENDENT INTERNAL THERMOMETER. OPERATOR INSTRUCTED TO REPAIR OR REPLACE THE COOLER IF ADJUSTMENTS ARE UNABLE TO MAKE IT FUNCTION IN A SAFE TEMPERATURE RANGE.

Comply By: 6/2/2025 Originally Issued On: 6/2/2025

Food & Beverage General Comment

FOOD AND BEVERAGE INSPECTION CONDUCTED AS PART OF HRD NURSING SURVEY OF ALF. IDENTIFIED FOOD SAFETY ISSUES ADDRESSED WITH ESTABLISHMENT REPRESENTATIVE DURING INSPECTION. ALF'S KITCHEN IS RESIDENTIAL AND SAME-DAY FOOD SERVICES ARE PROVIDED. FOOD SAFETY TOPICS COVERED: EMPLOYEE ILLNESS LOGGING, EXCLUSION, AND NOTIFICATION REQUIREMENTS; TEMPERATURE CONTROL; EMPLOYEE HYGIENE AND HAND WASHING; CROSS-CONTAMINATION; BARE HAND CONTACT WITH READY TO EAT FOODS; DATE MARKING AND LISTERIOSIS; AND SANITIZING THROUGH CHEMICAL AND HEAT. IDENTIFIED ISSUES CONVEYED TO NURSE SURVEYOR FOLLOWING INSPECTION.

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 F1029251019 from 6/2/2025

Trevor McCliment

MOUNIR AYOUB
LALD

Trevor McCliment,
Public Health Sanitarian 3
651-201-3957
trevor.mccliment@state.mn.us

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

Temperature Observations/Recordings

Establishment Info

Adequate Home Care LLC
Blaine
County/Group: Anoka County

Inspection Info

Report Number: F1029251019
Inspection Type: Full
Date: 6/2/2025
Time: 3:34:05 PM

Food Temperature: Product/Item/Unit: SLICED HAM**; Temperature Process:** Cold-Holding
Location: REFRIGERATOR at 43 Degrees F.
Comment:
Violation Issued?: Yes

Food Temperature: Product/Item/Unit: SLICED HAM**; Temperature Process:** Cold-Holding
Location: REFRIGERATOR at 48 Degrees F.
Comment:
Violation Issued?: Yes

Food Temperature: Product/Item/Unit: CREAM CHEESE**; Temperature Process:** Cold-Holding
Location: REFRIGERATOR at 45 Degrees F.
Comment:
Violation Issued?: Yes

Food Temperature: Product/Item/Unit: CREAM CHEESE**; Temperature Process:** Cold-Holding
Location: REFRIGERATOR at 47 Degrees F.
Comment:
Violation Issued?: Yes

Food Temperature: Product/Item/Unit: SOUR CREAM**; Temperature Process:** Cold-Holding
Location: REFRIGERATOR at 47 Degrees F.
Comment:
Violation Issued?: Yes

Food Temperature: Product/Item/Unit: OPENED CHICKEN BROTH**; Temperature Process:** Cold-Holding
Location: REFRIGERATOR at 48 Degrees F.
Comment:
Violation Issued?: Yes

Food Temperature: Product/Item/Unit: COOKED PIZZA**; Temperature Process:** Cooking
Location: JUST OUT OF OVEN at 172 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: SHELL EGG**; Temperature Process:** Cold-Holding
Location: REFRIGERATOR at 46 Degrees F.
Comment:
Violation Issued?: No

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

Sanitizer Observations/Recordings

Establishment Info

Adequate Home Care LLC
Blaine
County/Group: Anoka County

Inspection Info

Report Number: F1029251019
Inspection Type: Full
Date: 6/2/2025
Time: 3:34:05 PM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Kitchen **Equal To** 180 Degrees F.
Comment: THERMAL STICKER
Violation Issued?: No

Minnesota (MDH) Version
EH Manager; RPT: F1029251019

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	3	Date: 6/2/2025
No. of Repeat Risk Factor/Intervention/Violations		Time: 3:34:05 PM
Score (optional)		Dur: min

Establishment:	Address:	City/State:	Zip:	Phone:
Adequate Home Care LLC	10255 Madison Street NE	Blaine, MN	55434	
License/Permit #:	**Permit Holder:**	**Purpose of Inspection:**	**Est. Type:**	**Risk Category:**
HFID 39370		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	N/O	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	OUT	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	IN	Proper cooking time & temperatures		
19	N/O	Proper reheating procedures for hot holding		
20	N/O	Proper cooling time and temperature		
21	N/O	Proper hot holding temperatures		
22	OUT	Proper cold holding temperatures		
23	OUT	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	IN	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/O	Plant food properly cooked for hot holding		
35	N/O	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) Trevor McClime

Follow-up: Follow-up Date: