Electronically Delivered

October 30, 2026

Licensee
Shekky Care Services Professional Corporation
1160 Chicago Avenue
St Paul Park, MN 55071

RE: Project Number(s) SL40287016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 30, 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 - 0810 - 144g.45 Subd. 2 (b-F) - 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.

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

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40287	A. BUILDING: _____ B. WING _____	09/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEKKY CARE SERVICES PROFESSIONAL C(	1160 CHICAGO AVENUE ST PAUL PARK, MN 55071

(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: SL40287016-0 On September 28, 2026, through September 30, 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; three 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.	
0 430 SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services	0 430		

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0 430	Continued From page 1 (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to customize and provide the licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) to all residents. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) 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: R2 was admitted on May 12, 2026, to receive	0 430		

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0 430	Continued From page 2 assisted living services. R2's diagnosis included mild cognitive impairment of unknown etiology. R2's signed Uniform Disclosure of Assisted Living Services Agreement (UDALSA) document dated May 12, 2026, indicated the license utilized an uncustomized UDALSA document which lacked the required inclusion of the services provided by the licensee. On September 29, 2026, at 1:35 p.m., clinical nurse supervisor (CNS)-A stated the UDALSA "has not been customized," and stated, "this is the one we use," referring to the blank UDALSA presented by the surveyor. On September 30, 2026, at 12:10 p.m., licensed assisted living director (LALD)-C stated they knew the UDALSA needed to be provided during the admission process but was not aware the blank UDALSA form required modification. The licensee's 1.04 Uniform Disclosure of Assisted Living Services & Amenities (UDALSA) policy dated January 1, 2026, indicated the facility will provide a UDALSA to prospective residents prior to signing an Assisted Living contract. In addition, this policy indicated that the Minnesota department of Health (MDH) has provided the UDALSA, and the licensee will complete the provided form and keep current at all times. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 430		

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0 480	Continued From page 3	0 480		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 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;	0 480		

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0 480	Continued From page 4 (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 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 August 28, 2026, for the specific Minnesota Food Code violations. The Inspection	0 480		

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0 480	Continued From page 5 Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that 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 establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) for one of three staff (unlicensed personnel (ULP)-B). 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	0 660		

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0 660	Continued From page 6 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's TB facility risk assessment dated June 2026, indicated the licensee was at a low risk for TB transmission. ULP-B was hired March 13, 2025, to provide assisted living services. ULP-B's record contained a QuantiFERON TB Gold test which indicated that ULP-B had tested positive for TB. ULP-B's record contained a chest X ray with results indicating there was no active TB infection. ULP-B's record lacked documentation of a symptom screening. On September 29, 2026, at 1:46 p.m., clinical nurse supervisor (CNS)-A stated they remembered completing a symptom screening for ULP-B but believed it "likely did not get sent back after ULP-B received a chest X ray," explaining that the screening was "what is sent along so the testing facilities will know why the staff member is in need of testing." On September 30, 2026, at 12:11 p.m., licensed assisted living director (LALD)-C stated the symptom screening should be included in staff records. The licensee's 8.16 Tuberculosis Screening policy dated January 1, 2026, indicated the	0 660		

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0 660	Continued From page 7 licensee will establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report (MMWR). 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 (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	0 680		

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0 680	Continued From page 8 working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents receiving services under the assisted living license. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's EPP dated July 1, 2026, lacked the following required content: - a tracking system used to document locations of residents, staff, and relocation of staff; - develop policies and procedures which address role of the licensee under a waiver declared by the secretary in accordance with section 1135, and; - communication plan must include contact information for: - Federal, State, tribal, regional, and local EP staff; - State Licensing and Certification Agency; - MN Office of Ombudsman for LTC, and; - other sources of assistance. On September 30, 2026, at 12:14 p.m., licensed assisted living director (LALD)-C stated clinical nurse supervisor (CNS)-A "was responsible for	0 680		

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0 680	Continued From page 9 that." On September 30, 2026, at 12:31 p.m., CNS-A stated they were continuously developing the plan, and confirmed the missing EEP components had not yet been incorporated. The licensee's Emergency Preparedness Plan - Appendix Z compliance policy dated January 1, 2026, indicated the licensee would have in place an efective and compliant Emergency Preparedness Plan. The intent is the plan will be aligned with the Centers for Medicare and Medicaid Services State Operation Manual Appendix Z: "State Operations Manual Appendix Z - Emergency Preparedness for All Provides and Certified Supplier Types: Interpretive Guidance." Minnesota Administrative Rule 4659.0100 dated August 11, 2021, indicated assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.72, or successor requirements. This part referenced documents, specifications, methods, and standards in State Operations Manual Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types: Interpretive Guidance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
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	0 810		

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0 810	Continued From page 10 or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: 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	0 810		

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0 810	Continued From page 11 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 September 30, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for all of the licensee's residents.	0 910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40287	A. BUILDING: _____ B. WING _____	09/30/2026

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0 910	Continued From page 12 This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 was admitted on May 12, 2026, to receive assisted living services. R2's diagnosis included mild cognitive impairment of unknown etiology. R2's contract dated May 12, 2026, was missing required elements, including: - the legal name and health facility identification number of the facility; - the name, telephone number, and physical mailing address (not a post office box) of: - the facility and contracted service provider, when applicable; - the licensee of the facility; - the managing agent, if applicable; and - the authorized agent for the facility. On September 29, 2026, at 1:22 p.m., clinical nurse supervisor (CNS)-A verified that all residents utilized the same contract found in R2's record and stated they did not know that the information needed to be included in the contract. On September 30, 2026, at 12:15 p.m., licensed assisted living director (LALD)-C stated CNS-A "was responsible for developing the contract," and added they were assisting CNS-A while CNS-A completed coursework for their Licensed	0 910		

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0 910	Continued From page 13 Assisted Living Director credential. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910		
0 920 SS=C	144G.50 Subd. 2 (c) Contract information (c) The contract must include: (1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; (2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; (3) a delineation of the cost and nature of any other services to be provided for an additional fee; (4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; (5) a delineation of the grounds under which the resident may be transferred or have housing or services terminated or be subject to an emergency relocation; (6) billing and payment procedures and requirements; and (7) disclosure of the facility's ability to provide specialized diets. This MN Requirement is not met as evidenced by: Based on interview and record review, the	0 920		

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0 920	Continued From page 14 licensee failed to execute a written contract with the required content for all of the licensee's residents. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) 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: R2 was admitted on May 12, 2026, to receive assisted living services. R2's diagnosis included mild cognitive impairment of unknown etiology. R2's contract dated May 12, 2026, was missing required elements, including: - a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license. On September 29, 2026, at 1:22 p.m., clinical nurse supervisor (CNS)-A verified that all residents utilized the same contract found in R2's record and stated they did not know that the information needed to be included in the contract. On September 30, 2026, at 12:15 p.m., licensed assisted living director (LALD)-C stated CNS-A "was responsible for developing the contract," and added they were assisting CNS-A while CNS-A completed coursework for their Licensed Assisted Living Director credential.	0 920		

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0 920	Continued From page 15 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 920		
01330 SS=F	144G.60 Subd. 4 (b) Unlicensed personnel (b) Unlicensed personnel performing delegated nursing tasks in an assisted living facility must: (1) have successfully completed training and demonstrated competency by successfully completing a written or oral test of the topics in section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform; (2) satisfy the current requirements of Medicare for training or competency of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or 484.36; or (3) have, before April 19, 1993, completed a training course for nursing assistants that was approved by the commissioner. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for two of two unlicensed personnel (unlicensed personnel (ULP)-B, ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01330		

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01330	Continued From page 16 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: ULP-B ULP-B was hired March 13, 2025, to provide assisted living services. On September 29, 2026, from 8:01 a.m. to 9:43 a.m., the surveyor observed ULP-B provide assisted living services and administer medications to residents residing within the facility. ULP-D ULP-D was hired October 31, 2025, to provide assisted living services. ULP-B and ULP-D's employee records lacked documentation of the following training and competencies: - care and use of hearing aids; - standby assistance techniques and how to perform them; - basic nutrition, meal preparation, food safety, and assistance with eating; - preparation of modified diets as ordered by a licensed health professional; - safe transfer techniques and ambulation, and; - range of motioning and positioning. On September 29, 2026, at 1:22 p.m., clinical nurse supervisor (CNS)-A stated ULP-B and ULP-D did not receive the missing trainings as	01330		

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01330	Continued From page 17 the services were not being provided at the facility when they were hired and further stated their annual training dates were coming up, and they would ensure the missing trainings and competencies were added. The licensee's 5.02 Competency Training Evaluations policy dated January 1, 2025, indicated training and competency evaluations for all ULPs would include the following: - care and use of hearing aids; - standby assistance techniques and how to perform them; - basic nutrition, meal preparation, food safety, and assistance with eating; - preparation of modified diets as ordered by a licensed health professional; - safe transfer techniques and ambulation, and; - range of motioning and positioning. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01330		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services	01640		

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01640	Continued From page 18 and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure each resident had a current service plan with a signature or other authentication by the resident to document agreement on the services to be provided for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: R2 was admitted on May 12, 2026, to receive assisted living services. R2's diagnosis included mild cognitive impairment of unknown etiology. R2's service plan signed May 12, 2026, was a	01640		

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01640	Continued From page 19 blank fillable paper format service plan. The service plan lacked the following required components: - a description of the services to be provided, the fees for those services, and the frequency of each service according to the residents' current assessment and preferences; and - identification of the staff or staff categories who would provide the services. On September 29, 2026, at 2:30 p.m., clinical nurse supervisor (CNS)-A stated the provided service plan was what was given to the resident to sign during the admission process, and that the completed service plan was developed afterward. CNS-A stated they were unable to print from R Tasks (healthcare software) the day that R2 signed their service plan, and that R2's guardian was unable to sign the completed version. CNS-A further stated they did not document attempts at obtaining a signature from R2's guardian on the completed service plan. The licensee's 6.08 Service Plan policy dated January 1, 2026, indicated service plans will include a description of the services that are to be provided based on the most recent assessment and resident preferences and any revisions shall include a signature or other authentication by the licensee and by the resident, or resident's representative, documenting agreement on the services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		

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01880	Continued From page 20	01880		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prescription medications were securely locked in a substantially constructed compartment and permitted only authorized personnel to have access. This had the potential to affect all residents residing within the facility. 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 September 28, 2026, at 11:20 a.m., during a tour of the facility with clinical nurse supervisor (CNS)-A, the surveyor was able to access both the upstairs and downstairs medication cabinets without the use of keys, indicating the licensee failed to ensure medications were securely stored and accessible only to authorized individuals. The licensee utilized lockable metal filing cabinets with lockable drawers for storage of medications. The filing cabinets required the use of keys in order to	01880		

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01880	Continued From page 21 secure the drawers. The surveyor observed the cabinet held medications belonging to three of three residents residing within the facility. On September 29, 2026, from 8:18 a.m., to 9:50 a.m., the surveyor observed unlicensed personnel (ULP)-B access the two locked medication cabinets using a set of keys during morning medication administration. On September 30, 2026, at 12:49 p.m., CNS-A stated the staff "should be locking up the medication cabinet after they use the cabinet". The licensee's 7.11 Medication Storage policy dated January 1, 2026, indicated medications will be kept securely locked and stored per manufacturer's directions. Only authorized staff will have access to stored medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state	01910		

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01910	Continued From page 22 and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include the date of disposition and names of staff and other individuals involved in the disposition for one of one discharged residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 discharged from the licensee on June 9, 2026. R1's record contained a medication disposition form which lacked documentation of the following required contents of medication disposition: - prescription number, as applicable; - quantity of medications;	01910		

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01910	Continued From page 23 - the individual(s) to whom the medications were given; - the date of disposition; and - the names of staff and other individuals involved in the disposition. On September 29, 2026, at 12:38 p.m., clinical nurse supervisor (CNS)-A stated the provided document was "what was sent with R1 when they discharged," and confirmed no additional documentation of medication disposition was available. The licensee's 7.23 Medication Disposal policy dated January 6, 2024, indicated upon disposition, the facility must document in the resident's record the disposition of the expired medication including the medication's name, strength, prescription number as applicable, quantity, date of disposition, and names of staff and other individuals involved in the disposition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced	02320		

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02320	Continued From page 24 by: Based on observation, interview, and record review, the licensee failed to ensure one of one unlicensed personnel ((ULP)-B) followed appropriate medication administration procedures. 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: ULP-B was hired on March 13, 2025, to provide assisted living services. ULP-B's employee record indicated that they had completed medication administration training and competency on March 23, 2025. On September 29, 2026, at 8:18 a.m., the surveyor observed ULP-B unlock the medication cabinet, retrieve a pre-set medication container, and dump medications directly from the container into a medication cup before handing the cup to R4 without first verifying the medications against the medication administration record (MAR). After the resident received the medications, ULP-B then checked the MAR. On September 29, 2026, at 8:26 a.m., the surveyor observed ULP-B again retrieve a pre-set medication container, and dump medications directly from the container into a medication cup.	02320		

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SHEKKY CARE SERVICES PROFESSIONAL C(	1160 CHICAGO AVENUE ST PAUL PARK, MN 55071

(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
02320	Continued From page 25 At 8:34 a.m., the surveyor observed ULP-B hand the medication cup to R3 without first verifying all medications against the MAR. All medications were later documented as administered at 8:36 a.m. On September 29, 2026, at 9:54 a.m., during an interview, ULP-B stated the medications are set up by the RN and placed into pill boxes weekly. ULP-B stated they are supposed to verify meds against the MAR prior to administration. Additionally, ULP-B stated they had thought that they had completed their checks against the MAR, and it was possible the surveyor did not observe this. On September 30, 2026, at 12:46 p.m., clinical nurse supervisor (CNS)-A stated staff "were all trained to verify the meds against the MAR," and CNS-A planned to provide additional staff education. The licensee's 5.02 Competency Training Evaluations policy dated January 1, 2025, indicated the registered nurse will provide training and competency training for ULP's, and the training would include administering medications or treatments as required. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

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

SHEKKY CARE SERVICES PROFESSIO
1160 CHICAGO AVENUE
St Paul Park, MN 55071
Washington County
Parcel:

Phone:
shekkyservices@gmail.com

License Info

License: HFID 40287

Risk:
License:
Expires on:
CFPM: O Banjo
CFPM #: 120168; Exp: 11/27/2026

Inspection Info

Report Number: F1031261322
Inspection Type: Full - Single
Date: 9/28/2026 Time: 1pm
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 2
Total Priority 2 Orders: 3
Total Priority 3 Orders: 1
Delivery: Emailed

! **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:
CONDIMENTS STORED ON KITCHEN TABLE MEASURED 72F (AMBIENT).

ALL CONDIMENTS (ON TABLE) DISCARDED.

DISCONTINUE STORING ANY TEMPERATURE-CONTROLLED (TCS) PRODUCTS ON TABLE - PLACE BACK IN REFRIGERATOR AFTER USE.

Comply By: Complied On Site Originally Issued On: 9/28/2026

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:
STAFF NOT DATE MARKING HOT DOGS IN REFRIGERATOR.
STAFF DATE MARKED IMMEDIATELY.

Comply By: Complied On Site Originally Issued On: 9/28/2026

New Order: 4-300 Equipment Numbers and Capacities
4-302.14 *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.
COMMENT:
ESTABLISHMENT DOES NOT HAVE SANITIZER TESTING KIT ON SITE.
SANI TEST STRIPS LEFT ON SITE.
PURCHASE KIT AND TEST SANI CONCENTRATION (50-200PPM BLEACH, 150-400PPM QUAT) ON REGULAR BASIS.

Comply By: 10/2/2026 Originally Issued On: 9/28/2026

New Order: 6-100 Physical Facility Construction Materials
6-101.11A3 *Priority Level: Priority 3 CFP#: 55*
MN Rule 4626.1325A3 Provide nonabsorbent floor, wall, and ceiling surfaces for food preparation areas, walk-in refrigerators, warewashing areas, toilet rooms, all servicing areas, and areas subject to flushing or spray cleaning methods.
COMMENT:
FACILITY USING ABSORBENT LINERS FOR CUPBOARDS/SHELVING/DRAWERS.
DISCONTINUE USE OF ANY PAPER PRODUCTS FOR LINERS.
REPLACE WITH CONTACT PAPER, OR CLEANABLE LINERS AS DISCUSSED ON SITE.

Comply By: 10/19/2026 Originally Issued On: 9/28/2026

! **New Order: 7-200 Toxic Supplies and Applications**
7-204.11 *Priority Level: Priority 1 CFP#: 28*
MN Rule 4626.1620 Discontinue using chemical sanitizers, including chemical sanitizing solutions generated on site and other chemical antimicrobials on food-contact surfaces that do not meet the requirements specified in 40 CFR part 180, section 180.940, or part 180, subpart E, section 180.2020.
COMMENT:
DISINFECTANT BEING USED ON KITCHEN COUNTERTOPS.

DISCONTINUE USING STRONG, NON-APPROVED CHEMICALS ON KITCHEN COUNTERTOPS.

HAD STAFF PREPARE BLEACH & WATER SOLUTION IN ICE CREAM BUCKET (100PPM).

CONTINUE TO USE BLEACH & WATER SOLUTION IN BUCKET OR SPRAY BOTTLE AS DISCUSSED ON SITE.

Comply By: Complied On Site Originally Issued On: 9/28/2026

: 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:

Comply By: 9/28/2026 Originally Issued On: 9/28/2026

Food & Beverage General Comment

Nurse Evaluator on site: Zachary Morth

All violations discussed with PIC during the inspection.

NOTES:
Facility has a residential kitchen with the following finishes:
Composite flooring
Wood cabinetry
Stone countertops
Textured ceiling
Painted walls
2-comp sink with basin designated for handwashing.

Since establishment has a residential kitchen (4626.0506(G)(2)) Same-day service only. No saving and reheating of foods or preparation of foods the day prior to eating. Any remaining food from meals to be removed/discarded at end of day.

Discussed the following with pic:
Hand washing
Ware washing and dish machine temp (160F or greater)
Illness and illness log
No undercooked foods and cooking temps
Pasteurized egg use

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 F1031261322 from 9/28/2026

Elizabeth Banjo
Person in Charge

Chris Foster, REHS/RS
Public Health Sanitarian 3
651-201-4728
chris.j.foster@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

SHEKKY CARE SERVICES PROFESSIO
St Paul Park
County/Group: Washington County

Inspection Info

Report Number: F1031261322
Inspection Type: Full
Date: 9/28/2026
Time: 1pm

Food Temperature: Product/Item/Unit: Condiments (mayo, ketchup)**; Temperature Process:** Cold-Holding
Location: Table at 72 Degrees F.
Comment:
Violation Issued?: Yes

Food Temperature: Product/Item/Unit: Hot Dogs**; Temperature Process:** Cold-Holding
Location: Refrigerator at 40 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

SHEKKY CARE SERVICES PROFESSIO
St Paul Park
County/Group: Washington County

Inspection Info

Report Number: F1031261322
Inspection Type: Full
Date: 9/28/2026
Time: 1pm

Sanitizing Chemical: Product: Lysol Spray**; Sanitizing Process:** Spray Bottle
Location: Kitchen **Greater Than** 400 PPM
Comment: DISCONTINUE USE IN KITCHEN - TOO STRONG
Violation Issued?: No

Sanitizing Chemical: Product: Chlorine**; Sanitizing Process:** Wiping Cloth Bucket
Location: Kitchen **Equal To** 100 PPM
Comment:
Violation Issued?: No

New Record: Product: ; Sanitizing Process:
Location: Equal To
Comment:
Violation Issued?: No

Sanitizing Equipment: Product: Hot Water**; Sanitizing Process:** Dish Machine
Location: Kitchen **Equal To** 170 Degrees F.
Comment: Wax test strip used.
Violation Issued?: No

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL40287016	**Date:** 9/30/2026
Facility Name: Shekky Care Services	
Facility Address: 1160 Chicago Ave. St Paul, MN 55071	

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Twenty One (21) days

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

   Comments: The licensee failed to provide site-specific staff actions for evacuation during a fire or similar emergency. The FSEP contained general plans for staff actions during evacuation including a template floor plan but did not contain specific information relevant to the facility. Facility staff could not provide accurate and up to date staff action documentation to the surveyor. The FSEP should include site-specific staff actions for evacuation.

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

   Comments: The licensee failed to provide site-specific resident actions for evacuation during a fire or similar emergency. Only general information regarding resident actions or policy for evacuation was included in the FSEP and no further documentation was provided to the surveyor. The FSEP should include site-specific resident actions for evacuation.