Electronically Delivered

October 23, 2026

Licensee
Eleged Home Care Inc
2824 Oakland Avenue
Minneapolis, MN 55407

RE: Project Number(s) SL36008016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 23, 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.

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 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - $500.00
St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - $1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,500.00**. 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: Casey.DeVries@state.mn.us Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36008	A. BUILDING: _____ B. WING _____	09/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELEGED HOME CARE INC	2824 OAKLAND AVENUE MINNEAPOLIS, MN 55407

(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: SL36008016-0 On September 21, 2026, through September 23, 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.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the staffing plan was prepared and implemented by the clinical nurse supervisor (CNS) (as indicated in Minnesota Administrative Rule 4659.0180). The staffing plan was signed off by the licensed assisted living director (LALD), not the CNS. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 470		

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0 470	Continued From page 2 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 Staffing plan dated January 5, 2026, indicated that the staffing plan was prepared by licensed assisted living director (LALD)-B. On September 22, 2026, at 2:47 p.m., clinical nurse supervisor (CNS)-A stated they were not aware they were required to develop and implement the staffing plan and that it required biannual updates. The licensee's staffing policy dated February 2, 2024, indicated the nurse will prepare and implement a 24-hour daily staffing plan that ensures adequate staffing to meet residents' needs at all times, including reasonably foreseeable needs. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter	0 480		

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0 480	Continued From page 3 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part	0 480		

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0 480	Continued From page 4 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 September 21, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		

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0 510	Continued From page 5	0 510		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to establish and maintain an effective infection control program that complied with accepted health care, medical, and nursing standards for infection control related to gloving and hand hygiene for one of one employee observed (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On September 22, 2026, at 8:10 a.m., during	0 510		

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0 510	Continued From page 6 continuous observation, the surveyor observed ULP-C remove gloves and perform hand hygiene at the sink. At 8:11a.m., ULP-C put on new gloves and then retrieved medications for R2. At 8:17 a.m., ULP C removed gloves and did not complete hand hygiene. At 8:21 a.m., ULP-C donned new gloves without hand hygiene and began preparing oatmeal for the next resident. On September 22, 2026, at 2:19 p.m., ULP-C stated they were trained that they should complete hand hygiene between glove changes and, "I normally do it. I may have forgotten." The licensee's infection control policy dated July 30, 2021, indicated hands must be washed after removing gloves and before assisting with medications among several other required situations. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
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;	0 680		

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0 680	Continued From page 7 (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. Additionally, the licensee failed to post the EPP prominently. This had the potential to affect all residents receiving services under the provisional 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: On September 21, 2026, at 11:24 a.m., during a tour of the facility, the surveyor did not observe the licensee's EPP posted prominently. On September 21, 2026, at 11:24 a.m., clinical nurse supervisor (CNS)-A stated the EPP was stored in the office and locked overnight.	0 680		

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0 680	Continued From page 8 The licensee's undated EPP lacked the following required content: - policy and procedures must address use of volunteers including process and role for integration. The licensee's Emergency Preparedness policy dated July 31, 2021, indicated the licensee would have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. 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		
0 780 SS=F	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;	0 780		

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0 780	Continued From page 9 (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, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical	0 780		

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0 780	Continued From page 10 Environment Inspection Report (PEIR) dated September 22, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Two (2) days	0 780		
0 790 SS=D	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or	0 790		

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0 790	Continued From page 11 a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated September 22, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: 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	0 800		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELEGED HOME CARE INC	2824 OAKLAND AVENUE MINNEAPOLIS, MN 55407

(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
0 800	Continued From page 12 resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated September 22, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=I	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be	0 810		

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0 810	Continued From page 13 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 three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated September 22, 2026, for the specific violations related the physical environment under Minnesota Statute 144G.	0 810		

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0 810	Continued From page 14 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waving the licensee's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted July 20, 2022, to receive assisted living services.	0 970		

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0 970	Continued From page 15 R1's diagnoses included chronic obstructive pulmonary disease, depression, and knee abscess. R1's service plan dated September 8, 2025, indicated that R1 received assisted living services to include activity assistance, ambulation, bathing assistance, compression stockings, housekeeping, laundry, behavior management, medication administration, medication setup, safety checks, transfer assistance, and wound care. R1's record contained a contract signed on December 1, 2025. R2 R2 was admitted on December 13, 2021, to receive assisted living services. R2's diagnoses included insulin dependent diabetes mellitus, depression, post-traumatic stress disorder, anxiety, and hypertension. R2's service plan dated September 8, 2025, indicated R2 received assistance with diabetic equipment care, laundry, behavior management, meal assistance, medication administration, medication setup, blood glucose monitoring, and safety checks. R2's record contained a contract signed on July 1, 2025. R1 and R2's Assisted Living Contracts, included the following language indicating a waiver of liability on page 12 and page 13: -"Miscellaneous Provisions: 1. Insurance Liability and Release. The resident shall maintain at all	0 970		

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0 970	Continued From page 16 times his or her own health, personal property, liability, automobile (if applicable), and other insurance coverages and shall provide evidence of same by copies of binders or policies provided to [Licensee] upon request. The resident acknowledges that [Licensee] is not an insurer of the resident's person or property. The resident agrees that [Licensee] will not be liable to the resident for any personal injury or property damage (including, without limitation, damage to, or loss or theft of, automobiles or personal property of resident) suffered by the resident or the resident's agents, guests or invitees, unless and to the extent that the injury or damage is caused by the negligence of [Licensee] Care or its employees or agents. The resident hereby releases [Licensee] from liability for any personal injury or property damage suffered by the resident ... unless caused by the negligence of [Licensee] or its employees or agents." On September 23, 2026, at approximately 1:00 p.m., licensed assisted living director (LALD)-B stated they had drafted a new contract since their last survey in which the liability waiver was taken out. LALD-B stated they must have reissued the old contract in error. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
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:	01530		

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01530	Continued From page 17 (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 for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by:	01530		

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01530	Continued From page 18 Based on interview and record review, the licensee failed to complete two hours of initial training on mental illness and de-escalation for employees hired prior to July 1, 2025, for two of three employees (clinical nurse supervisor (CNS)-A , unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: CNS-A CNS A was hired June 1, 2020, to provide clinical oversight. CNS A's record contained 1.25 hours of mental health training. CNS-A's record lacked documentation of the required initial two hours of dementia care training. ULP-D ULP-D was hired December 30, 2022, to provide assisted living services. ULP-D's record contained 1.25 hours of mental health trainings. ULP-D's record lacked documentation of the required initial two hours of dementia care training. On September 22, 2026, at 2:34 p.m., CNS-A stated they mistakenly assigned annual mental health training instead of initial mental health	01530		

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01530	Continued From page 19 training for long term staff, which resulted in long-term staff only receiving 1.5 hours of annual training. The licensee's policies did not address the statutory requirement for mental illness and de-escalation training. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01530		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's	01620		

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01620	Continued From page 20 needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a reassessment not to exceed 90 days for two of two residents (R1, 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 a widespread scope (when problems are pervasive or represent a systemic	01620		

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01620	Continued From page 21 failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted on July 20, 2022, to receive assisted living services. R1's diagnoses included chronic obstructive pulmonary disease, depression, and knee abscess. R1's service plan dated September 8, 2025, indicated that R1 received assisted living services to include activity assistance, ambulation, bathing assistance, compression stockings, housekeeping, laundry, behavior management, medication administration, medication setup, safety checks, transfer assistance, and wound care. R1's record contained a 90-day assessment dated January 15, 2026. R1's next assessment occurred on April 19, 2026, which indicated 94 days lapsed between assessments. R1's next assessment date occurred on July 21, 2026, which indicated 93 days lapsed between assessment dates. R2 R2 was admitted on December 13, 2021, to receive assisted living services. R2's diagnoses included insulin dependent diabetes mellitus, depression, post-traumatic stress disorder, anxiety, and hypertension. R2's service plan dated September 8, 2025, indicated R2 received assistance with diabetic	01620		

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01620	Continued From page 22 equipment care, laundry, behavior management, meal assistance, medication administration, medication setup, blood glucose monitoring, and safety checks. R2's record contained a 90-day assessment dated January 7, 2026. R2's next assessment occurred on April 13, 2026, which indicated 96 days lapsed between assessments. R2's next assessment date occurred on July 21, 2026, which indicated 99 days lapsed between assessment dates. On September 22, 2026, at 2:40 p.m., clinical nurse supervisor (CNS)-A stated late assessments happened frequently as residents were frequently absent when there were scheduled appointments. The licensee's Assessment and Reassessment policy dated October 5, 2022, indicated ongoing resident reassessments must be conducted by an RN and cannot exceed 90 days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of	01760		

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01760	Continued From page 23 administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medication administration was accurately documented and failed to follow medication administration protocol for one of three 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 was admitted on July 20, 2022, to receive assisted living services. R1's diagnoses included chronic obstructive pulmonary disease, depression, and knee abscess. R1's service plan dated September 8, 2025, indicated that R1 received assisted living services to include activity assistance, ambulation, bathing assistance, compression stockings, housekeeping, laundry, behavior management,	01760		

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01760	Continued From page 24 medication administration, medication setup, safety checks, transfer assistance, and wound care. R1's 90-day assessment dated July 21, 2026, indicated that due to memory issues and a history of poor compliance, R1 required medication administration assistance. R1's medication administration record indicated that R1 had received 60 milligrams (mg) of liquid methadone at 10:21 a.m., on September 21, 2026. On September 21, 2026, at 11:24 a.m., during a tour of the facility the surveyor observed an unopened bottle of liquid methadone on the bedside table in R1's bedroom. The surveyor observed the bottle contained a pink colored liquid with a plastic tape seal over the cap of the bottle. On September 21, 2026, at 11:39 a.m., R1 stated the methadone on the bedside table was a medication they take in the morning. R1 stated they did not like to take their methadone right away as it makes them sleepy. On September 22, 2026, at 2:21 p.m., unlicensed personnel (ULP)-C stated they passed the administered methadone the previous morning prior to the arrival of the surveyor and had left the liquid methadone with the resident. ULP-C stated they normally give methadone after food and take back the empty container. ULP-C stated the resident requested it be left and it was left in error. On September 22, 2026, at 2:44 p.m., clinical nurse supervisor (CNS)-A stated the methadone	01760		

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01760	Continued From page 25 observed on the bedside table within R1's room should been given to the resident and should have been observed being consumed rather than the ULP leaving the medication unattended in R1's room. CNS-A stated R1 had previously convinced staff to leave the methadone in the room unattended, and this has been an issue they had been working with staff on. The licensee's Medication Documentation policy dated July 30, 2021, indicated that each medication administered by staff will be documented in the resident's clinical record. Documentation will be complete, accurate, and legible. Residents' needs will be met related to the Medication Management Plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
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.	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36008	A. BUILDING: _____ B. WING _____	09/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELEGED HOME CARE INC	2824 OAKLAND AVENUE MINNEAPOLIS, MN 55407

(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
01880	Continued From page 26 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 21, 2026, at 11:24 a.m., during a tour of the facility the surveyor observed an unopened bottle of liquid methadone on the bedside table in R1's bedroom. The surveyor observed pink colored liquid inside of a small plastic bottle with a plastic tape seal over the cap of the bottle. On September 22, 2026, at 9:00 a.m., during a morning medication pass the surveyor observed a small, round pink tablet with an "I" engraving. The small pill was located on the second floor of the facility in a hallway that connected all three bedrooms. The surveyor pointed out the pill to unlicensed personnel (ULP)-C. ULP-C stated R2 routinely pocketed (held medications in their mouth) or spit out pills and would throw them in the hallway. The surveyor observed ULP-C then left the medication in the hallway instead of picking the medication up and securing the medication. On September 22, 2026, at 9:05, the surveyor pointed out the dropped medication in the hallway to clinical nurse supervisor (CNS)-A. CNS-A picked the medication up with a gloved hand and secured the medication for later identification and	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36008	A. BUILDING: _____ B. WING _____	09/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELEGED HOME CARE INC	2824 OAKLAND AVENUE MINNEAPOLIS, MN 55407

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01880	Continued From page 27 disposal. On September 22, 2026, at 9:17 a.m., CNS-A identified the medication as R2's 20 milligram (mg) rosuvastatin (a prescription medicine used to treat high cholesterol and to reduce the risk of major cardiovascular events such as heart attack and stroke). On September 22, 2026, at 2:25 p.m., ULP-C stated they were trained to inform the nurse but gave no explanation as to why they did not complete the task upon discovery of the medication. On September 22, 2026, at 2:42 p.m., CNS-A stated staff should have secured the medication and then informed the registered nurse when the medication was discovered. On September 22, 2026, at 2:44 p.m., CNS-A stated the methadone observed on the bedside table within R1's room should been given to the resident and should have been observed being consumed rather than the ULP leaving the medication unattended in R1's room. CNS-A stated R1 had previously convinced staff to leave the methadone in the room unattended, and this has been an issue they had been working with staff on. The licensee's Storage/Control of Medications policy dated July 30, 2021, indicated all prescription drugs must be securely locked in substantially constructed compartments, accessible only to authorized personnel. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36008	A. BUILDING: _____ B. WING _____	09/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELEGED HOME CARE INC	2824 OAKLAND AVENUE MINNEAPOLIS, MN 55407

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01880	Continued From page 28 days	01880		

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

ELEGED HOME CARE INC
2824 OAKLAND AVENUE
Minneapolis, MN 55407
Hennepin County
Parcel:

Phone:

License Info

License: HFID 36008

Risk:
License:
Expires on:
CFPM: MOHAMED SHUKRI
CFPM #: 53566; Exp: 10-08-2027

Inspection Info

Report Number: F1062261214
Inspection Type: Full - Single
Date: 9/21/2026 Time: 12:00 pm
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 1
Total Priority 2 Orders: 0
Total Priority 3 Orders: 3
Delivery: Emailed

New Order: 2-100 Supervision
2-102.12DMN *Priority Level: Priority 3 CFP#: 2*
MN Rule 4626.0033D Post the certified food protection manager certificate.
COMMENT: CFPM CERTIFICATE NO PRESENT ON SITE. FACILITY DOES HAVE A CFPM. ENSURE CFPM CERTIFICATE IS POSTED IN FACILITY.
Comply By: 9/21/2026 Originally Issued On: 9/21/2026

! **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: OBSERVED RAW SHELL EGGS STORED ABOVE READY-TO-EAT PRODUCE IN REFRIGERATOR. ENSURE RAW ANIMAL PROTEINS ARE STORED SUCH THAT RISK OF CROSS-CONTAMINATION OF READY-TO-EAT FOODS IS MINIMIZED.
Comply By: 9/21/2026 Originally Issued On: 9/21/2026

New Order: 3-300C Protection from Contamination: equipment/utensils, consumers
3-305.11A *Priority Level: Priority 3 CFP#: 39*
MN Rule 4626.0300A Store all food in a clean, dry location; where it is not exposed to splash, dust or other contamination; and at least 6 inches above the floor.
COMMENT: OBSERVED BASKET OF GINGER ROOT STORED ON SHELF OF SHELVING UNIT LESS THAN 6 INCHES ABOVE THE FLOOR. FOOD WAS REMOVED FROM BOTTOM SHELF TO A HIGHER ONE. ENSURE FOOD IS STORED AT LEAST 6 INCHES ABOVE THE FLOOR.
Comply By: 9/21/2026 Originally Issued On: 9/21/2026

New Order: 4-100 Equipment Construction Materials
4-101.17 *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0490 Discontinue using wood and wood wicker as a food contact surface.
COMMENT: OBSERVED WOOD SPOON BEING USED IN KITCHEN. ENSURE UTENSILS ARE COMPOSED OF APPROVED MATERIALS FOR FOOD CONTACT SURFACES.
Comply By: 9/21/2026 Originally Issued On: 9/21/2026

Food & Beverage General Comment

INSPECTION COMPLETED ON BEHALF OF ZACHARY MORTH OF HRD.
FACILITY USES A RESIDENTIAL KITCHEN. TILE FLOOR, LAMINATE COUNTERTOP, DRYWALL, 2 BASIN SINK WITH LEFT BASIN DEDICATED TO HANDWASHING.

DISCUSSED LEFTOVER PROHIBITIONS, UTENSIL MATERIALS, ILLNESS RECORDING, AND STORAGE OF RAW ANIMAL PROTEINS.

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 F1062261214 from 9/21/2026

MOHAMED SHUKRI
CFPM

Nicholas Streeter, RS
Public Health Sanitarian 2
nicholas.streeter@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

ELEGED HOME CARE INC
Minneapolis
County/Group: Hennepin County

Inspection Info

Report Number: F1062261214
Inspection Type: Full
Date: 9/21/2026
Time: 12:00 pm

Equipment Temperature: Product/Item/Unit: FRIDGE/FREEZER UNIT**; Temperature Process:** Cold-Holding
Location: 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

ELEGED HOME CARE INC
Minneapolis
County/Group: Hennepin County

Inspection Info

Report Number: F1062261214
Inspection Type: Full
Date: 9/21/2026
Time: 12:00 pm

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Kitchen **Equal To** 175 Degrees F.
Comment:
Violation Issued?: No

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL36008016-0	**Date:** September 22, 2026
Facility Name: ELEGED HOME CARE INC	
Facility Address: 2824 OAKLAND AVE, Minneapolis, MN, 55407	

☒ **TAG IDENTIFICATION: 0780**

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

1. Smoke alarms interconnected so that actuation of one alarm causes all alarms in the individual dwelling or sleeping unit to operate where more than one smoke alarm is required within an individual dwelling or sleeping unit. [Minn. Stat. 144G.45 subd.2]

   Comments: Battery powered smoke alarm in resident room two was not interconnected with the rest of the facility alarms when tested.

☒ **TAG IDENTIFICATION: 0790**

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

1. Portable fire extinguishers installed and maintained to MN State Fire Code. [Minn. Stat. 144G.45 subd.2]

   Comments: The facility fire extinguisher in the kitchen had not been annually serviced by a licensed technician.

☒ **TAG IDENTIFICATION: 0800**

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

1. The physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment are 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. [Minn. Stat. 144G.45 subd.2]

   Comments: In the basement next to the furnace there were several piles of cat feces.

   The basement mop sink had been used to dump a liquid that then dried and clogged the sink.

   In resident room two the top closet door hinge was not secure to the door frame.

   In the upper-level bathroom, the wood frame window in the shower had the lower section separated from the rest of the frame.

   The rear exterior light had a broken light bulb still screwed in.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 3; Widespread **TIME PERIOD OF CORRECTION:** Twenty One (21) days

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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 FSEP 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 plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate).

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

   Comments: The FSEP did not identify specific fire protection actions for residents. There was no section in the plan that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency.

3. 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. [Minn. Stat. 144G.45 subd.2]

Comments: The licensed assisted living director (LALD)-B/clinical nurse supervisor (CNS)-A lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan.

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

   Comments: CNS-A/LALD-B, lacked documentation showing evacuation drills occurred twice per year, per shift, with at least one evacuation drill every other month. *No other information or documentation was provided.*