Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

September 8, 2026

Licensee
ADA Homes INC
8730 Oregon Avenue North
Brooklyn Park, MN 55445

RE: Project Number(s) SL42323015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial survey on August 6, 2026, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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

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

DOCUMENTATION OF ACTION TO COMPLY
Per 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 residents/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 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 the Department of Health within 15 calendar days of the correction order receipt date.

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers.

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,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 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
	42323	A. BUILDING: _____ B. WING _____	08/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADA HOMES INC	8730 OREGON AVE N BROOKLYN PARK, MN 55445

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER 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: SL42323015-0 On August 3, 2026, through August 6, 2026, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were two (2) residents; 2 receiving services under the Provisional Assisted Living 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 License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL 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 observation, interview, and record review, the licensee failed to develop and implement a written staffing plan that included an evaluation completed by the clinical nurse supervisor (CNS) at least twice a year and to ensure a current staffing schedule was posted as required. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a	0 470		

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0 470	Continued From page 2 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: The licensee held an assisted living facility license for a capacity of five (5) residents and had a current census of two (2) residents. STAFFING PLAN On August 3, 2026, at approximately 10:10 a.m., during the entrance conference, licensed assisted living director (LALD)-A stated one unlicensed personnel (ULP) worked each shift and the shift schedule was 8:00 a.m. to 4:00 p.m., 4:00 p.m. to 11:00 p.m., and 11:00 p.m. to 8:00 a.m. LALD-A also stated he was unaware of what the staffing plan was. On August 3, 2026, at 11:20 a.m., CNS-B stated she did not complete a written staffing plan that included an evaluation completed by CNS-B at least twice a year and they were unaware of the requirement. STAFFING SCHEDULE On August 3, 2026, at approximately 11:10 a.m., during a tour of the facility, the surveyor observed postings on a wall in the hallway by the front entrance and on a wall in the dining room area. The surveyor did not observe a posted daily staffing schedule for the licensee. On August 3, 2026, at approximately 11:15 a.m.,	0 470		

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0 470	Continued From page 3 LALD-A and CNS-B confirmed the licensee did not post a staffing schedule. CNS-B stated they were unaware of the staffing schedule posting requirement. The licensee's 4.06 Staffing & Scheduling policy dated March 20, 2026, indicated the CNS would develop and implement a written staffing plan that included an evaluation completed by the CNS twice per year and to ensure a current staffing schedule was posted as required. Minnesota Administrative Rule 4659.0180, Subpart 4 dated August 11, 2021, indicated the clinical nurse supervisor must develop a 24-hour daily staffing schedule. The schedule must: (1) include direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked; and (2) identify the direct-care staff member's resident assignments or work location. The daily work schedule must be posted, after redacting direct-care staff members' resident assignments, at the beginning of each work shift in a central location in each building of a facility or campus, accessible to staff, residents, volunteers, and the public. The facility shall not disclose any information that is protected by law from public disclosure. No further information was 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	0 480		

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

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0 480	Continued From page 5 and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated August 3, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee via email within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer	0 480		

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0 480	Continued From page 6 to the FBEIR for any compliance dates.	0 480		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the required information related to the grievance procedure and contact information for the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances, and the contact information for the Offices of Ombudsmans for Long-Term Care (OOLTC) and Mental Health and Developmental Disabilities (OOMHDD). This had the potential to affect all the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a	0 550		

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0 550	Continued From page 7 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 August 3, 2026, at approximately 11:15 a.m., during a facility tour, the common areas shared by residents, staff, and visitors lacked a posting of the grievance procedure to include the name, telephone number, and e-mail contact information for the individuals who were responsible for handling resident grievances and contact information for the OOLTC and OOMHDD. On August 3, 2026, at approximately 11:20 a.m., licensed assisted living director (LALD)-A confirmed the required content was not posted in the common areas. LALD-A stated they were unaware the licensee's grievance procedure had to be posted and the licensee's grievance procedure was available in a folder. The licensee's 2.10 Complaint/Grievance Posting policy dated March 20, 2026, indicated the licensee would post the grievance procedure with the required information in the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		

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0 630	Continued From page 8	0 630		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop an individual abuse prevention plan (IAPP) with the required content 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 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee was licensed for a bed capacity of five (5) residents and had a current census of two (2) residents. R1	0 630		

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0 630	Continued From page 9 R1 was admitted on May 22, 2026. On August 3, 2026, at approximately 1:05 p.m., clinical nurse supervisor (CNS)-B stated R1's most current IAPP was included in R1's 14-day RN Assessment. R1's IAPP dated June 5, 2026, on page six (6), under the section Vulnerability, indicated R1 was at risk of being abused and did not include: - the resident's susceptibility to abuse by another individual, including other vulnerable adults; and - statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. R2 R2 was admitted on March 3, 2026. On August 3, 2026, at approximately 1:10 p.m., CNS-B stated R2's most current IAPP was included in R2's latest 90-day RN Assessment. R2's IAPP dated June 18, 2026, on page seven (7), under the section Vulnerability, indicated R2 was at risk of being abused and did not include: - the resident's susceptibility to abuse by another individual, including other vulnerable adults; and - statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. On August 3, 2026, at approximately 1:30 p.m., CNS-B confirmed R1 and R2's IAPPs did not address the above noted areas of risk or include statements of specific measures to be taken to minimize risks. CNS-B stated they were unaware of all the required contents of the IAPP, and the IAPP was completed based on the questions shown in the electronic health record.	0 630		

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0 630	Continued From page 10 The licensee's 6.05 Individual Abuse Prevention Plan policy dated March 20, 2026, indicated the licensee would develop and implement IAPPs that included the resident's susceptibility to be abused by another individual, including other vulnerable adults, and specific measures to minimize the risk of abuse to that person and other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment as	0 640		

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0 640	Continued From page 11 required. This had the potential to affect all the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when 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 August 3, 2026, at approximately 11:20 a.m., during a facility tour, the common areas shared by residents, staff, and visitors lacked a posting of information for reporting maltreatment to include the reporting number for the Minnesota Adult Abuse Reporting Center (MAARC). On August 3, 2026, at approximately 11:25 a.m., licensed assisted living director (LALD)-A confirmed the required MAARC content was not posted in the common areas. LALD-A stated they were unsure why the MAARC information was not posted and the licensee would post the required MAARC information. The licensee's 2.44 Vulnerable Adult Maltreatment - Prevention & Reporting policy dated March 20, 2026, indicated contact information for MAARC would be posted in the facility by the licensee. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records included all required content for four of four employees (licensed assisted living director (LALD)-A, clinical nurse supervisor (CNS)-B, unlicensed personnel (ULP)-C, 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	0 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	42323	A. BUILDING: _____ B. WING _____	08/06/2026

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0 650	Continued From page 13 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 August 3, 2026, at approximately 10:00 a.m., during the entrance conference, LALD-A stated they were responsible for all the licensee's onboarding and orientation requirements for the licensee. LALD-A LALD-A was hired on January 15. 2026. LALD-A's employee record lacked documentation of a job description for LALD-A. CNS-B CNS-B was hired on February 20, 2026. CNS-B's employee record lacked documentation of a job description for CNS-B. ULP-C ULP-C was hired on February 16, 2026. ULP-C's employee record lacked documentation of a job description for ULP-C. ULP-D ULP-D was hired on February 15, 2026. ULP-D's employee record lacked documentation of a job description for ULP-D. On August 3, 2026, at approximately 3:30 p.m., LALD-A confirmed that no job descriptions were	0 650		

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0 650	Continued From page 14 completed for LALD-A, CNS-B, ULP-C, and ULP-D. LALD-A stated they forgot to complete a job description for employees and was unsure why. The licensee's 4.05 Employees Records policy, undated, indicated the licensee would include a current signed job description in the employee's records. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a 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	0 660		

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0 660	Continued From page 15 tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) when the licensee failed to complete a facility TB risk assessment, a TB history and symptom screen for four of four employees (licensed assisted living director (LALD)-A, clinical nurse supervisor (CNS)-B, unlicensed personnel (ULP)-C, ULP-D), and TB testing for two of four employees (ULP-C, 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 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: TB FACILITY RISK ASSESSMENT On August 3, 2026, at approximately 10:15 a.m., during the entrance conference, LALD-A stated CNS-B was responsible for completing the facility TB risk assessment and was unsure if the facility TB risk assessment was completed. On August 3, 2026, at approximately 11:05 a.m., CNS-B stated she was aware of the facility TB risk assessment requirement but had not completed a facility TB risk assessment and did not provide a reason why. TB HISTORY AND SYMPTOM SCREEN LALD-A LALD-A had a hire date of January 15, 2026.	0 660		

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0 660	Continued From page 16 LALD-A's employee record lacked documentation of a completed TB history and symptom screen. CNS-B CNS-B had a hire date of February 20, 2026. CNS-B's employee record lacked documentation of a completed TB history and symptom screen. ULP-C ULP-C had a hire date of February 16, 2026. ULP-C's employee record lacked documentation of a completed TB history and symptom screen. ULP-D ULP-D had a hire date of February 15, 2026. ULP-D's employee record lacked documentation of a completed TB history and symptom screen. On August 3, 2026, at approximately 3:05 p.m., LALD-A stated they were unaware of the employee TB history and screen requirement and a TB history and screen was not completed for any employee of the licensee. TB TESTING ULP-C ULP-C's employee record included one TB skin test dated July 7, 2025, but lacked documentation of a completed second TB skin test. ULP-D ULP-D's employee record included one TB skin test dated April 3, 2024, but lacked documentation of a completed second TB skin test. On August 3, 2026, at approximately 3:10 p.m.,	0 660		

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0 660	Continued From page 17 CNS-B confirmed ULP-C and ULP-D did not complete a second TB skin test and stated they were unaware of the requirement. The licensee's 8.16 Tuberculosis Screening policy, dated March 20, 2026, indicated the licensee would complete a facility TB risk assessment, and baseline screening was completed at time of hire for all direct care providers and testing results would be kept in each employee medical file. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and the CDC guidelines, indicated a TB infection control program should include a facility TB risk assessment. The guidelines also indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's	01470		

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01470	Continued From page 18 policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and	01470		

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01470	Continued From page 19 the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure orientation with all the required content was completed for three of four employees (licensed assisted living director (LALD)-A, clinical nurse supervisor (CNS)-B, 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 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 August 3, 2026, at approximately 10:00 a.m., during the entrance conference, LALD-A stated they were responsible for all the licensee's employee orientation requirements for the	01470		

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01470	Continued From page 20 licensee. LALD-A LALD-A was hired on January 15. 2026. LALD-A's employee record lacked documentation of a completed orientation to assisted living regulations with the required content related to: -overview of Assisted Living statues; -review of provider's policies and procedures; -handling of resident complaints, reporting of complaints, where to report; and -consumer advocacy services. CNS-B CNS-B was hired on February 20, 2026. CNS-B's employee record lacked documentation of a completed orientation to assisted living regulations with the required content related to: -review of provider's policies and procedures; and -handling of resident complaints, reporting of complaints, where to report. ULP-C ULP-C was hired on February 16, 2026. ULP-C's employee record lacked documentation of a completed orientation to assisted living regulations with the required content related to: -review of provider's policies and procedures; and -consumer advocacy services. On August 3, 2026, at approximately 3:40 p.m., LALD-A confirmed the above noted orientation content were not completed for LALD-A, CNS-B, and ULP-C. LALD-A stated they were unaware of all the required orientation to be completed for employees of the licensee.	01470		

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01470	Continued From page 21 The licensee's Orientation & Training policy dated March 20, 2026, indicated the required orientation content would be provided to employees. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01530 SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on	01530		

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01530	Continued From page 22 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: Based on interview and record review, the licensee failed to ensure all employees received eight hours of initial dementia care training and two hours of mental illness and de-escalation training within the first 160 working hours of employment for direct care employees as required for one of three employees (licensed assisted living director (LALD)-A) and within the first 120 working hours of employment for supervisors of direct care staff as required for one of one supervisor (clinical registered nurse (CNS)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	01530		

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01530	Continued From page 23 On August 3, 2026, at approximately 10:00 a.m., during the entrance conference, LALD-A stated they were responsible for all the licensee's employee orientation requirements for the licensee. LALD-A LALD-A was hired on January 15. 2026, to provide direct care working full time (40 hours a week) for the licensee. LALD-A's employee file included two (2) and a half (0.5) hours of completed dementia training and lacked the required eight (8) hours of initial dementia care training and 2 hours of mental illness and de-escalation training within the first 160 working hours of employment. CNS-B CNS-B was hired on February 20, 2026, to supervise direct care staff working two (2) to three (3) days a week for the licensee. CNS-B's employee file did not include any dementia or mental illness training and lacked the required 8 hours of initial dementia care training and 2 hours of mental illness and de-escalation training within the first 120 working hours of employment. On August 3, 2026, at approximately 3:45 p.m., LALD-A confirmed the required initial dementia and mental illness training were not completed by LALD-A and CNS-B. LALD-A stated they were unaware of all the required initial dementia and mental illness training. The licensee's 5.03 Dementia Training policy dated March 20, 2026, indicated the licensee	01530		

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01530	Continued From page 24 would meet the dementia and mental illness training requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
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 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 the current service plan included a signature or other authentication by	01640		

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01640	Continued From page 25 the licensee and the resident or resident's designated representative to document agreement on the services to be provided for one of two 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: The licensee was licensed for a bed capacity of five (5) residents and had a current census of two (2) residents. R1 was admitted on May 22, 2026. On August 3, 2026, at 1:45 p.m., R1's service plan, dated May 22, 2026, was provided by clinical nurse supervisor (CNS)-B who indicated it was R1's current service plan with services R1 was receiving. R1's Service Plan was neither signed nor authenticated by a licensee's representative or R1. On August 3, 2026, at approximately 1:55 p.m., CNS-B confirmed R1's service plan was not signed or authenticated by a licensee's representative or R1 and did not provide a reason why. On August 3, 2026, at approximately 2:00 p.m.,	01640		

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01640	Continued From page 26 licensed assisted living director (LALD)-A stated R2's service plan was signed by the licensee and R2 but was unsure why R1's service plan was not signed by either the licensee or R1. The licensee's 6.08 Service Plan policy dated March 20, 2026, indicated the initial service plan, and any revisions to the resident's service plan would be signed by the resident or the resident's representative and the licensee's representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01650 SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	42323	A. BUILDING: _____ B. WING _____	08/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADA HOMES INC	8730 OREGON AVE N BROOKLYN PARK, MN 55445

(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
01650	Continued From page 27 identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the residents' service plan included all required content for one of two 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: The licensee was licensed for a bed capacity of five (5) residents and had a current census of two (2) residents. R1 was admitted on May 22, 2026. On August 3, 2026, at 1:45 p.m., R1's service plan, dated May 22, 2026, was provided by clinical nurse supervisor (CNS)-B who indicated it was R1's current service plan with services R1 was receiving.	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	42323	A. BUILDING: _____ B. WING _____	08/06/2026

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01650	Continued From page 28 R1's service plan lacked the required content below: -fees for services; -schedule and methods of monitoring assessments of resident; -schedule and methods of monitoring staff providing services; -contingency plan that included the action taken if the schedule service cannot be provided; and -information for the emergency contact. On August 3, 2026, at approximately 1:55 p.m., CNS-B confirmed R1's service plan lacked the above listed required content and stated they were unaware of all the required content for the resident's service plan. On August 3, 2026, at approximately 2:00 p.m., licensed assisted living director (LALD)-A stated the licensee used a different service plan document that contained all the required content for R2, but R1's service plan was from R1's electronic record and did not realize R1's service plan lacked all the required content. The licensee's 6.08 Service Plan policy dated March 20, 2026, indicated the licensee service plan would include all the required content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		

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

ADA Homes Inc
8730 Oregon Ave N
Brooklyn Park, MN 55445
Hennepin County
Parcel:

Phone:

License Info

License: HFID 42323

Risk:
License:
Expires on:
CFPM: DEBESAY GIRMALUL
CFPM #: 4953; Exp: 12-12-2027

Inspection Info

Report Number: F1062261164
Inspection Type: Full - Single
Date: 8/3/2026 Time: 12:10 pm
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 1
Delivery: Emailed

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 SPOONS IN DRAWERS AT FACILITY. ENSURE UTENSILS ARE MADE FROM APPROVED FOOD-CONTACT MATERIALS.
Comply By: 8/3/2026 Originally Issued On: 8/3/2026

Food & Beverage General Comment

INSPECTION CONDUCTED ON BEHALF OF CARL SAMROCK HRD.

DISCUSSED UTENSIL MATERIAL COMPOSITION, VOMIT CLEAN-UP PROCEDURES, STORING EMPLOYEE ITEMS, AND PROHIBITIONS ON UNDERCOOKED FOODS AND LEFTOVERS.

FACILITY USES TWO BASIN SINK WITH ONE BASIN DEDICATED TO HANDWASHING.
LAMINATE COUNTERS, TILE FLOOR AND BACKSPLASH

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 F1062261164 from 8/3/2026

DEBESAY GIRMALUL
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

ADA Homes Inc
Brooklyn Park
County/Group: Hennepin County

Inspection Info

Report Number: F1062261164
Inspection Type: Full
Date: 8/3/2026
Time: 12:10 pm

Food Temperature: Product/Item/Unit: LACTAID MILK**; Temperature Process:** Cold-Holding
Location: Refrigerator at 41 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

ADA Homes Inc
Brooklyn Park
County/Group: Hennepin County

Inspection Info

Report Number: F1062261164
Inspection Type: Full
Date: 8/3/2026
Time: 12:10 pm

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: KITCHEN **Equal To** 170 Degrees F.
Comment: THERMOLABEL LEFT WITH FACILITY, PHOTO OF LABEL SENT TO SANITARIAN BY STAFF
Violation Issued?: No