



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 21, 2025

Licensee

Unique Homes LLC

4922 Newton Avenue North

Minneapolis, MN 55430

RE: Project Number(s) SL35310016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 24, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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 - 0340 - 144g.30 Subd. 5 - Correction Orders - \$500.00

St - 0 - 0800 - 144g.45 Subd. 2 (a) (4) - 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

Unique Homes LLC

October 21, 2025

Page 3

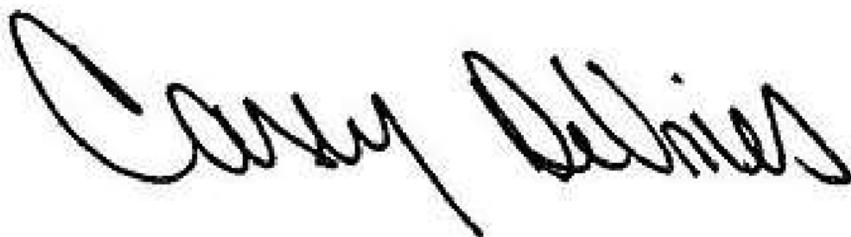
may request a reconsideration or a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: <https://forms.office.com/g/Bm5uQEPhVa>. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in black ink that reads "Casey DeVries". The signature is written in a cursive, flowing style.

Casey DeVries, Supervisor

State Evaluation Team

Email: Casey.DeVries@state.mn.us

Telephone: 651-201-5917 Fax: 1-866-890-9290

CLN

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2025
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER UNIQUE HOMES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4922 NEWTON AVENUE NORTH MINNEAPOLIS, MN 55430
-------------------------------------------------------------	----------------------------------------------------------------------------------------------------

(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	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.</p> <p>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.</p> <p>INITIAL COMMENTS:</p> <p>SL35310016-0</p> <p>On September 22, 2025, through September 24, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were four residents all of whom received services under the Assisted Living Facility license.</p>	0 000	<p>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.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>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.</p>	
0 340 SS=F	144G.30 Subd. 5 Correction orders	0 340		

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
---------------------------------------------------------------------------------------------------------	-------	-----------

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2025
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER UNIQUE HOMES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4922 NEWTON AVENUE NORTH MINNEAPOLIS, MN 55430
-------------------------------------------------------------	----------------------------------------------------------------------------------------------------

(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
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	--------------------

0 340	<p>Continued From page 1</p> <p>(a) A correction order may be issued whenever the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or staff of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction.</p> <p>(b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically.</p> <p>(c) By the correction order date, the facility must:</p> <p>(1) document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed; and</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide sufficient documentation taken to comply with the correction orders from a survey completed January 6, 2023. The lack of action to ensure compliance with regulations had the potential to affect all residents receiving services from the licensee.</p> <p>This practice resulted in a level two violation (a</p>	0 340		
-------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2025
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER UNIQUE HOMES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4922 NEWTON AVENUE NORTH MINNEAPOLIS, MN 55430
-------------------------------------------------------------	----------------------------------------------------------------------------------------------------

(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
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	--------------------

0 340	<p>Continued From page 2</p> <p>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).</p> <p>The findings include:</p> <p>On February 15, 2023, the licensee received results from the previous survey concluded on January 6, 2023. The longest time period for correction (the time frame the licensee must document and correct orders) was 21 days from the date the licensee received their results, which was March 8, 2023. The licensee's correction orders included tag identifiers 0680, 1620, 1650, and 1710, related to 144G.42 Subd.10 disaster planning and emergency preparedness, 144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring, 144G.70 Subd. 4 (f) Service plan, implementation, and revisions to service plan, and 144G.71 Subd. 3 Individualized medication monitoring and reassessment.</p> <p>The licensee's plan of correction titled Corrections, with multiple dates from January 5, 2023, through January 30, 2023, lacked corrective action taken for order numbers 1620, 1650, and 1710.</p> <p>On September 24, 2025, at 1:00 p.m., upon completion of a survey initiated on September 22, 2025, the surveyor found the licensee was still non-compliant with tag order identifiers 0680, 1620, 1650, and 1710.</p> <p>On September 24, 2025, at 10:02 a.m., the</p>	0 340		
-------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2025
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER UNIQUE HOMES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4922 NEWTON AVENUE NORTH MINNEAPOLIS, MN 55430
-------------------------------------------------------------	----------------------------------------------------------------------------------------------------

(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
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	--------------------

0 340	<p>Continued From page 3</p> <p>surveyor inquired how the licensee took corrective action after the previous survey for tag identifiers 1620, 1650, and 1710. Licensed assisted living director (LALD)-D stated for tag identifier 1620 assessments, the licensee followed the Minnesota Department of Health (MDH) requirement of initial assessments, 14-day assessments, 90-day assessments, and change of condition assessments. LALD-D stated for tag identifier 1650 service plans, the licensee created the Service/Care Plan document, and they believed they created the new service plan to meet the requirement. LALD-D stated for tag identifier 1710 medication assessments, the licensee completed the assessments when a resident admitted. The surveyor inquired if they completed further medication assessments after the initial medication assessment. LALD-D stated, "I don't quite remember. Two or three times per year they fill out the form for med assessment."</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	0 340		
0 480 SS=F	<p>144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services</p> <p>(a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626.</p> <p>(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</p>	0 480		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2025
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER UNIQUE HOMES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4922 NEWTON AVENUE NORTH MINNEAPOLIS, MN 55430
-------------------------------------------------------------	----------------------------------------------------------------------------------------------------

(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
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	--------------------

0 480	<p>Continued From page 4</p> <p>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;</p> <p>(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;</p> <p>(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;</p> <p>(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;</p> <p>(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;</p> <p>(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</p> <p>(7) notwithstanding Minnesota Rules, part</p>	0 480		
-------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2025
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER UNIQUE HOMES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4922 NEWTON AVENUE NORTH MINNEAPOLIS, MN 55430
-------------------------------------------------------------	----------------------------------------------------------------------------------------------------

(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
0 480	<p>Continued From page 5</p> <p>4626.1390, toilet rooms are not required to be provided with a self-closing door.</p> <p>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.</p> <p>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).</p> <p>The findings include:</p> <p>Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated September 23, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.</p> <p>TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.</p>	0 480		
0 630 SS=E	<p>144G.42 Subd. 6 (b) Compliance with requirements for reporting ma</p> <p>(b) The facility must develop and implement an individual abuse prevention plan for each</p>	0 630		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2025
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER UNIQUE HOMES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4922 NEWTON AVENUE NORTH MINNEAPOLIS, MN 55430
-------------------------------------------------------------	----------------------------------------------------------------------------------------------------

(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
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	--------------------

0 630	<p>Continued From page 6</p> <p>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.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have an accurate individual abuse prevention plan (IAPP) for two of three residents (R1, R3).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).</p> <p>The findings include:</p> <p>R1 R1 admitted to the licensee on August 1, 2021, and began receiving assisted living services.</p> <p>R1's diagnoses included brain injury and unspecified psychosis (condition in which one is unable to distinguish, in one's own experience of life, between what is and is not real.)</p>	0 630		
-------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2025
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER UNIQUE HOMES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4922 NEWTON AVENUE NORTH MINNEAPOLIS, MN 55430
-------------------------------------------------------------	----------------------------------------------------------------------------------------------------

(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
0 630	<p>Continued From page 7</p> <p>R1's record included two service plans.</p> <p>R1's Service Plan signed January 20, 2025, indicated, "see exhibit 1 for level of care and charges". R1's Service Plan lacked "exhibit 1". The service plan did not identify any services the licensee would provide to R1.</p> <p>R1's Service/Care Plan signed August 1, 2021, indicated R1 received assistance with appointments, shopping, homemaking, arranging non-medical transportation, meals, socialization, transportation, dressing, grooming, bathing, medication management, and behavior management.</p> <p>R1's Individual Abuse Prevention Plan Assessment dated September 21, 2025, indicated R1 was not at risk for abusing other vulnerable adults.</p> <p>R1's undated Customized Living Preliminary Behavior Plan indicated R1 shouts angrily at others, name calls, has a history and continues to threaten others through gestures when they are angry or not getting out of their way, and "she exhibits anger toward staff and other residents."</p> <p>R3 R3 admitted to the licensee on June 7, 2024, and began receiving assisted living services.</p> <p>R3's diagnoses included asthma, schizophrenia (a mental health condition characterized by hallucinations, delusions, and disorganized thinking), and bipolar.</p> <p>R3's record included two service plans.</p>	0 630		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2025
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER UNIQUE HOMES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4922 NEWTON AVENUE NORTH MINNEAPOLIS, MN 55430
-------------------------------------------------------------	----------------------------------------------------------------------------------------------------

(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
0 630	<p>Continued From page 8</p> <p>R3's Service Plan signed January 20, 2025, indicated, "see exhibit 1 for level of care and charges". R3's Service Plan lacked "exhibit 1". The service plan did not identify any services the licensee would provide to R3.</p> <p>R3's undated and unsigned Service/Care Plan indicated R3 received assistance with homemaking, shopping, appointments, socialization, meals, and medication management.</p> <p>R3's Individual Abuse Prevention Plan Assessment dated May 24, 2025, indicated R3 was not at risk for abusing other vulnerable adults.</p> <p>R3's Customized Living Preliminary Behavior Plan dated July 19, 2024, read, "[R3] manifests as hostile or confrontational language directed towards others." In addition, the behavior plan indicated R3's outbursts could be hurtful or intimidating to those around them.</p> <p>R1 and R3's IAPP did not accurately reflect R1 and R3's risk of abusing other vulnerable adults.</p> <p>On September 23, 2025, at 1:40 p.m., clinical nurse supervisor (CNS)-C stated R1 and R3 were not physically violent however, had verbal behaviors towards others. CNS-C stated verbal behaviors were "mostly" directed towards staff and that was why they did not indicate the residents were at risk of abusing other vulnerable adults.</p> <p>The licensee's Individual Abuse Prevention Plan Policy dated January 15, 2025, indicated an IAPP</p>	0 630		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2025
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER UNIQUE HOMES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4922 NEWTON AVENUE NORTH MINNEAPOLIS, MN 55430
-------------------------------------------------------------	----------------------------------------------------------------------------------------------------

(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
0 630	Continued From page 9 would be completed for each resident upon admission and the IAPP would identify the resident's vulnerabilities, potential risks for abuse or self-neglect, and measures to minimize those risks. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule.	0 680		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2025
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER UNIQUE HOMES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4922 NEWTON AVENUE NORTH MINNEAPOLIS, MN 55430
-------------------------------------------------------------	----------------------------------------------------------------------------------------------------

(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
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	--------------------

0 680	<p>Continued From page 10</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors.</p> <p>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).</p> <p>The findings include:</p> <p>The licensee's emergency disaster preparedness plan dated September 22, 2025, lacked evidence of the following required content: - quarterly review of the missing resident plan; and - emergency prep testing requirements to include exercises to test the EPP at least twice per year.</p> <p>On September 23, 2025, at 2:00 p.m., licensed assisted living director (LALD)-D stated they reviewed the licensee missing resident plan twice per year. LALD-D stated the licensee completed fire drills however, they had not completed a disaster drill at the facility and would complete one once the survey was complete.</p> <p>The licensee's Emergency Plan Policy dated January 15, 2025, indicated the licensee</p>	0 680		
-------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2025
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER UNIQUE HOMES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4922 NEWTON AVENUE NORTH MINNEAPOLIS, MN 55430
-------------------------------------------------------------	----------------------------------------------------------------------------------------------------

(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
0 680	Continued From page 11 maintained an all-hazard emergency plan that outlines preparedness, response, and recovery procedures for natural disasters, fire, medical emergencies, utility failures, pandemics and other threats. In addition, the purpose of the policy was to comply with Minnesota Department of Health (MDH) emergency preparedness requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=D	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing	0 780		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2025
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER UNIQUE HOMES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4922 NEWTON AVENUE NORTH MINNEAPOLIS, MN 55430
-------------------------------------------------------------	----------------------------------------------------------------------------------------------------

(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
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	--------------------

0 780	<p>Continued From page 12</p> <p>buildings may be battery operated;</p> <p>This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that functioned and were interconnected so that the actuation of one alarm caused all alarms in the dwelling unit to actuate. This had the potential to directly affect all residents, staff, and visitors.</p> <p>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).</p> <p>The findings include:</p> <p>On September 24, 2025, from 10:00 a.m. to 11:30 a.m., the surveyor toured the facility with administrator (A)-F and housing manager (HM)-E. The surveyor asked A-F to initiate a test of the smoke alarms throughout the home. Upon testing, it was found that the smoke alarms in the stairwell up to the second level and in the basement gym were not interconnected with the other smoke alarms in the facility. The non-interconnected smoke alarms were battery powered and removed at the time of the survey.</p>	0 780		
-------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2025
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER UNIQUE HOMES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4922 NEWTON AVENUE NORTH MINNEAPOLIS, MN 55430
-------------------------------------------------------------	----------------------------------------------------------------------------------------------------

(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
0 780	Continued From page 13 There was no smoke alarm installed in the basement outside and in the immediate vicinity of bedroom 4. These deficient conditions were visually verified at the time of discovery by A-F and HM-E accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 800 SS=I	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, in a continuous state of good repair and operation. This had the potential to directly affect all residents, staff, and visitors. 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	0 800		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2025
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER UNIQUE HOMES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4922 NEWTON AVENUE NORTH MINNEAPOLIS, MN 55430
-------------------------------------------------------------	----------------------------------------------------------------------------------------------------

(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	<p>Continued From page 14</p> <p>problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>On September 24, 2025, from 10:00 a.m. to 12:30 p.m., the surveyor toured the facility with administrator (A)-F and housing manager (HM)-E. The following was observed.</p> <p>DESIGNATED SMOKING AREA: The designated smoking area was a screened in patio attached to the side of the detached garage. The patio structure was heavily weathered and not maintained in good repair or operation. The structure was significantly compromised.</p> <ul style="list-style-type: none"> - The knee wall (low brick wall of the screened porch) had missing and damaged bricks adjacent to the paver patio outside the front of the screen porch. - The columns on each end of the structure had significant water damage and appeared to be rotting where they rested on the knee wall. - The wood deck boards were damaged in a few locations and had a 12 inch piece missing under the patio table. - The wood pieces that made the frames for the screens were damaged and missing in multiple locations. Nails and sharp pieces of wood protruded from the structure where damage occurred. - The screens were ripped or missing on all three sides of the structure. - The roof structure had significant water damage. Multiple roof purlins (horizontal structural members that span between the roof joists) had dropped over an inch from their 	0 800		
-------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2025
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER UNIQUE HOMES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4922 NEWTON AVENUE NORTH MINNEAPOLIS, MN 55430
-------------------------------------------------------------	----------------------------------------------------------------------------------------------------

(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	<p>Continued From page 15</p> <p>adjacent wood joist (a horizontal structural beam that provides support for a flat or low-sloped roof and its sheathing).</p> <ul style="list-style-type: none"> - The roof sheathing (the layer of boards or panels that is attached to a roof's structure to create the solid, flat base for all other roofing materials) had significant water damage and was sagging over the entire roof. Parts of the roof sheathing had completely collapsed and were missing from multiple locations leaving entire sections of the roof with gaping holes in it. <p>EXTERIOR FACADE: The exterior of the building was damaged in multiple locations leaving the interior structure vulnerable to water penetration/ mold growth, structural instability/ rot, and rodent/ insect infestation.</p> <ul style="list-style-type: none"> - The exterior dryer vent did not have an appropriate cover to act as a barrier to prevent pests, debris, and drafts from entering the home through the dryer vent, while allowing lint-filled air to escape. - The sealant joint between the exterior brick sill and cladding was damaged or missing in multiple locations. Some of the bricks were broken or missing at the top and bottom of the wall. - The wood trim around the windows of the living room and bedrooms on the main level had significant weathering, broken and protruding wood splinters, and signs of rodent/bird nesting between the window pane and window screens. <p>LAUNDRY ROOM:</p> <ul style="list-style-type: none"> - The lay-in ceiling tiles and grid were broken, hanging down, or missing from over half the ceiling. - The thermal and sound control insulation between each floor joist was exposed to the 	0 800		
-------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2025
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER UNIQUE HOMES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4922 NEWTON AVENUE NORTH MINNEAPOLIS, MN 55430
-------------------------------------------------------------	----------------------------------------------------------------------------------------------------

(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	<p>Continued From page 16</p> <p>laundry room which is a higher hazard space due to the lint producing appliances found inside. The insulation was not installed according to manufacturer's instructions. The facing of the insulation read "Warning! This facing will burn. Do not leave exposed. It must be covered with gypsum board or other code-approved materials and installed in compliance with all building codes. To prevent a fire, keep open flames and other sources of heat away from the facing."</p> <p>These deficient conditions were visually verified at the time of discovery by A-F and HM-E accompanying on the tour.</p> <p>On September 24, 2025, HM-E and A-F stated the building was owned by someone else and they were renting the building.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Two (2) days</p>	0 800		
0 810 SS=F	<p>144G.45 Subd. 2 (b-f) Fire protection and physical environment</p> <p>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:</p> <ul style="list-style-type: none"> (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 	0 810		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2025
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER UNIQUE HOMES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4922 NEWTON AVENUE NORTH MINNEAPOLIS, MN 55430
-------------------------------------------------------------	----------------------------------------------------------------------------------------------------

(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
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	--------------------

0 810	<p>Continued From page 17</p> <p>or unusual resident needs for movement or evacuation.</p> <p>(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.</p> <p>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.</p> <p>(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.</p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content. This had the potential to directly affect all residents, staff, and visitors.</p> <p>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</p>	0 810		
-------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2025
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER UNIQUE HOMES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4922 NEWTON AVENUE NORTH MINNEAPOLIS, MN 55430
-------------------------------------------------------------	----------------------------------------------------------------------------------------------------

(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
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	--------------------

0 810	<p>Continued From page 18</p> <p>affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>On September 24, 2025, administrator (A)-F and house manager (HM)-E provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility.</p> <p>EVACUATION DIAGRAMS: The evacuation plan diagrams were not posted in the building. Staff posted the diagrams after the survey had started.</p> <p>FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, Fire Safety Policy for Residents, dated August 1, 2024, failed to include the following:</p> <p>The FSEP did not identify specific fire protection actions for residents. There policy section that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency did not accurately describe what a resident should do in a fire or how to evacuate the building. The section also incorrectly indicated that the facility was equipped with a central fire alarm system, emergency lighting, and sprinkler system.</p> <p>On September 24, 2025, at 1:30 p.m., A-F stated they would update their policy to be more accurate and specific to the facility.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	0 810		
-------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2025
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER UNIQUE HOMES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4922 NEWTON AVENUE NORTH MINNEAPOLIS, MN 55430
-------------------------------------------------------------	----------------------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01060	Continued From page 19	01060		
01060 SS=F	<p>144G.52 Subd. 9 Emergency relocation</p> <p>(a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination.</p> <p>(b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum:</p> <ul style="list-style-type: none"> (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. <p>(c) The notice required under paragraph (b) must be delivered as soon as practicable to:</p> <ul style="list-style-type: none"> (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not 	01060		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2025
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER UNIQUE HOMES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4922 NEWTON AVENUE NORTH MINNEAPOLIS, MN 55430
-------------------------------------------------------------	----------------------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	--------------------

01060	<p>Continued From page 20</p> <p>returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, or designated representative for one of one resident (R1).</p> <p>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).</p> <p>The findings include:</p> <p>R1 admitted to the licensee on August 1, 2021, and began receiving assisted living services.</p> <p>R1's record included two service plans.</p> <p>R1's Service Plan signed January 20, 2025, indicated, "see exhibit 1 for level of care and charges". R1's Service Plan lacked "exhibit 1". The service plan did not identify any services the licensee would provide to R1.</p> <p>R1's Service/Care Plan signed August 1, 2021, indicated R1 received assistance with</p>	01060		
-------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2025
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER UNIQUE HOMES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4922 NEWTON AVENUE NORTH MINNEAPOLIS, MN 55430
-------------------------------------------------------------	----------------------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	--------------------

01060	<p>Continued From page 21</p> <p>appointments, shopping, homemaking, arranging non-medical transportation, meals, socialization, transportation, dressing, grooming, bathing, medication management, and behavior management.</p> <p>R1's progress notes dated September 4, 2025, through September 17, 2025, indicated R1 was sent to the hospital on January 13, 2024, due to suicidal ideation and returned to the licensee's facility on February 14, 2024.</p> <p>R1's record lacked evidence that the licensee provided the resident or resident's representative a written emergency relocation notice.</p> <p>On September 23, 2025, at 10:02 a.m., licensed assisted living director (LALD)-D stated they did not have an emergency relocation notice for R1. LALD-D stated they interpreted the regulation that the licensee would provide an emergency relocation notice to the resident and/or designated representative and the office of ombudsman only if the resident was in the hospital for four days. LALD-D stated they only provided the emergency relocation notice to residents who were relocated for four days or more.</p> <p>The licensee's 1.23 Emergency Relocation policy dated August 1, 2021, indicated in the event of an emergency relocation, the licensee would provide a written notice that contains at a minimum:</p> <ul style="list-style-type: none"> - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of 	01060		
-------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2025
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER UNIQUE HOMES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4922 NEWTON AVENUE NORTH MINNEAPOLIS, MN 55430
-------------------------------------------------------------	----------------------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	--------------------

01060	Continued From page 22 Ombudsman for Long-Term Care; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and - a statement that if the facility refused to provide housing or services after a relocation, the resident has the right to appeal. In addition, the notice was required to be delivered as soon as practicable to the resident, legal representative, or designated representative and for the residents who received home and community-based waiver services, the residents case manager. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01620 SS=E	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	01620		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2025
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER UNIQUE HOMES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4922 NEWTON AVENUE NORTH MINNEAPOLIS, MN 55430
-------------------------------------------------------------	----------------------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	--------------------

01620	<p>Continued From page 23</p> <p>resident's needs and reflect person-centered planning and care delivery.</p> <p>(c) Resident reassessment and monitoring must be conducted by a registered nurse:</p> <p>(1) no more than 14 calendar days after initiation of services;</p> <p>(2) as needed based on changes in the resident's needs; and</p> <p>(3) at least every 90 calendar days.</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>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 ongoing resident reassessments</p>	01620		
-------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2025
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER UNIQUE HOMES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4922 NEWTON AVENUE NORTH MINNEAPOLIS, MN 55430
-------------------------------------------------------------	----------------------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	--------------------

01620	<p>Continued From page 24</p> <p>that did not exceed 90 days for two of three residents (R2, R3). In addition, the licensee failed to complete an accurate assessment related to resident's activities of daily living (ADL) needs for one of three residents (R3).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).</p> <p>The findings include:</p> <p>R2 R2 admitted to the licensee on August 7, 2020, under the licensee's previous comprehensive license and began receiving assisted living services on August 1, 2021.</p> <p>R2's diagnoses included schizoaffective disorder (mental health condition marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as depression and mania), bipolar disorder (mental health condition that causes significant mood changes that can disrupt daily life), and neurocognitive disorder due to a traumatic brain injury.</p> <p>R2's record included two service plans.</p> <p>R2's Service Plan signed January 20, 2025, indicated, "see exhibit 1 for level of care and</p>	01620		
-------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2025
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER UNIQUE HOMES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4922 NEWTON AVENUE NORTH MINNEAPOLIS, MN 55430
-------------------------------------------------------------	----------------------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	<p>Continued From page 25</p> <p>charges". R2's Service Plan lacked "exhibit 1". The service plan did not identify any services the licensee would provide to R2.</p> <p>R2's Service/Care Plan signed July 31, 2023, indicated R2 received assistance with homemaking, shopping, appointments, arranging non-medical appointments, socialization, meals, dressing, grooming, bathing, walking, medication management, and behavior management.</p> <p>R2's medical record included ongoing assessments dated March 21, 2025, June 21, 2025, and September 21, 2025, indicating 92 days passed between the March 21, 2025, assessment and the June 21, 2025, assessment and 92 days passed between the June 21, 2025, assessment and the September 21, 2025, assessment.</p> <p>R3 R3 admitted to the licensee on June 7, 2024, and began receiving assisted living services.</p> <p>R3's diagnoses included asthma, schizophrenia (a mental health condition characterized by hallucinations, delusions, and disorganized thinking), and bipolar.</p> <p>R3's record included two service plans.</p> <p>R3's Service Plan signed January 20, 2025, indicated, "see exhibit 1 for level of care and charges". R3's Service Plan lacked "exhibit 1". The service plan did not identify any services the licensee would provide to R3.</p> <p>R3's undated and unsigned Service/Care Plan indicated R3 received assistance with</p>	01620		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2025
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER UNIQUE HOMES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4922 NEWTON AVENUE NORTH MINNEAPOLIS, MN 55430
-------------------------------------------------------------	----------------------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	--------------------

01620	<p>Continued From page 26</p> <p>homemaking, shopping, appointments, socialization, meals, and medication management.</p> <p>R3's medical record included ongoing assessments dated May 24, 2025, and August 24, 2025, indicating 92 days passed between the two assessments. In addition, R3's ongoing assessment dated August 24, 2025, indicated R3 was independent for ambulation, transfers, bed mobility, eating, grooming, dressing, and bathing and R3 self-administered medications. R3 did not need cues or reminders or staff assistance for the ADLs listed above.</p> <p>R3's care task check off dated September 1, 2025, through September 21, 2025, indicated staff assisted R3 with ADL support for dressing, grooming, bathing, and medication administration, reminder, setup, and monitoring.</p> <p>On September 23, 2025, at 1:35 p.m., clinical nurse supervisor (CNS)-C stated the licensee completed initial, 14-day, 90-day, and change of condition assessments. CNS-C stated, "honestly I do 90 days plus one or two days after." The surveyor explained how 90-day assessments could not be completed passed 90 calendar days. CNS-C stated, "It is something I am learning. Didn't think it would be a big deal." In addition, CNS-C stated R3 required cues for ADLs and medication reminders. CNS-C stated they marked independent on R3's assessment because they did not require assistance after they were cued for ADLs or medication.</p> <p>The licensee's Client Assessment Policy dated August 1, 2021, indicated the licensee would conduct and document resident assessments at</p>	01620		
-------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2025
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER UNIQUE HOMES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4922 NEWTON AVENUE NORTH MINNEAPOLIS, MN 55430
-------------------------------------------------------------	----------------------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 27 the following intervals: - initial assessment- prior to or at the time services begin; - comprehensive assessment- within 14 calendar days after services begin; - ongoing assessments- at least every 90-calendar day thereafter; and - change of condition assessment - whenever there was a significant change in the resident's condition, needs, or preferences. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01650 SS=F	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		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2025
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER UNIQUE HOMES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4922 NEWTON AVENUE NORTH MINNEAPOLIS, MN 55430
-------------------------------------------------------------	----------------------------------------------------------------------------------------------------

(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	<p>Continued From page 28</p> <p>identification of and information as to who has authority to sign for the resident in an emergency; and</p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included all required content for three of three residents (R1, R2, R3).</p> <p>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).</p> <p>The findings include:</p> <p>R1 R1 admitted to the licensee on August 1, 2021, and began receiving assisted living services.</p> <p>R1's diagnoses included brain injury and unspecified psychosis (condition in which one is unable to distinguish, in one's own experience of life, between what is and is not real.)</p> <p>On September 23, 2025, at 8:18 a.m., the surveyor observed unlicensed personnel (ULP)-A</p>	01650		
-------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2025
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER UNIQUE HOMES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4922 NEWTON AVENUE NORTH MINNEAPOLIS, MN 55430
-------------------------------------------------------------	----------------------------------------------------------------------------------------------------

(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	<p>Continued From page 29</p> <p>administer medication to R1.</p> <p>R1's record included two service plans.</p> <p>R1's Service Plan signed January 20, 2025, indicated, "see exhibit 1 for level of care and charges". R1's Service Plan lacked "exhibit 1". The service plan did not identify any services the licensee would provide to R1. R1's service plan lacked the following required content:</p> <ul style="list-style-type: none"> - a description of the services to be provided including frequency of each service; and - identification of staff who would provide the services. <p>R1's Service/Care Plan signed August 1, 2021, indicated R1 received assistance with appointments, shopping, homemaking, arranging non-medical transportation, meals, socialization, transportation, dressing, grooming, bathing, medication management, and behavior management. The service plan lacked the following required content:</p> <ul style="list-style-type: none"> - the identification of staff or categories of staff who will provide the services; - the schedule and methods of monitoring assessments of the resident; - the schedule and methods of monitoring staff providing services; and -a contingency plan that includes: <ul style="list-style-type: none"> -the action to be taken if the scheduled service cannot be provided; -information and a method to contact the facility; -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 identification of and information as to who has 	01650		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2025
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER UNIQUE HOMES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4922 NEWTON AVENUE NORTH MINNEAPOLIS, MN 55430
-------------------------------------------------------------	----------------------------------------------------------------------------------------------------

(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	<p>Continued From page 30</p> <p>authority to sign for the resident in an emergency; and</p> <p>-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.</p> <p>R2 R2 admitted to the licensee on August 7, 2020, under the licensee's previous comprehensive license and began receiving assisted living services on August 1, 2021.</p> <p>R2's diagnoses included schizoaffective disorder (mental health condition marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as depression and mania), bipolar disorder (mental health condition that causes significant mood changes that can disrupt daily life), and neurocognitive disorder due to a traumatic brain injury.</p> <p>R2's record included two service plans.</p> <p>R2's Service Plan signed January 20, 2025, indicated, "see exhibit 1 for level of care and charges". R2's Service Plan lacked "exhibit 1". The service plan did not identify any services the licensee would provide to R2. R2's service plan lacked the following required content: - a description of the services to be provided including frequency of each service; and - identification of staff who would provide the services.</p> <p>R2's Service/Care Plan signed July 31, 2023, indicated R2 received assistance with</p>	01650		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2025
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER UNIQUE HOMES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4922 NEWTON AVENUE NORTH MINNEAPOLIS, MN 55430
-------------------------------------------------------------	----------------------------------------------------------------------------------------------------

(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	<p>Continued From page 31</p> <p>homemaking, shopping, appointments, arranging non-medical appointments, socialization, meals, dressing, grooming, bathing, walking, medication management, and behavior management. The service plan lacked the following required content:</p> <ul style="list-style-type: none"> - the identification of staff or categories of staff who will provide the services; - the schedule and methods of monitoring assessments of the resident; - the schedule and methods of monitoring staff providing services; and -a contingency plan that includes: <ul style="list-style-type: none"> -the action to be taken if the scheduled service cannot be provided; -information and a method to contact the facility; -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 identification of and information as to who has authority to sign for the resident in an emergency; and -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. <p>R3 R3 admitted to the licensee on June 7, 2024, and began receiving assisted living services.</p> <p>R3's diagnoses included asthma, schizophrenia (a mental health condition characterized by hallucinations, delusions, and disorganized thinking), and bipolar.</p>	01650		
-------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2025
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER UNIQUE HOMES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4922 NEWTON AVENUE NORTH MINNEAPOLIS, MN 55430
-------------------------------------------------------------	----------------------------------------------------------------------------------------------------

(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	<p>Continued From page 32</p> <p>R3's record included two service plans.</p> <p>R3's Service Plan signed January 20, 2025, indicated, "see exhibit 1 for level of care and charges". R3's Service Plan lacked "exhibit 1". The service plan did not identify any services the licensee would provide to R3. R3's service plan lacked the following required content:</p> <ul style="list-style-type: none"> - a description of the services to be provided including frequency of each service; and - identification of staff who would provide the services. <p>R3's undated and unsigned Service/Care Plan indicated R3 received assistance with homemaking, shopping, appointments, socialization, meals, medication management. The service plan lacked the following required content:</p> <ul style="list-style-type: none"> - authentication by the resident or residents representative; - the identification of staff or categories of staff who will provide the services; - the schedule and methods of monitoring assessments of the resident; - the schedule and methods of monitoring staff providing services; and -a contingency plan that includes: <ul style="list-style-type: none"> -the action to be taken if the scheduled service cannot be provided; -information and a method to contact the facility; -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 identification of and information as to who has authority to sign for the resident in an emergency; and 	01650		
-------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2025
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER UNIQUE HOMES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4922 NEWTON AVENUE NORTH MINNEAPOLIS, MN 55430
-------------------------------------------------------------	----------------------------------------------------------------------------------------------------

(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	<p>Continued From page 33</p> <p>-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.</p> <p>On September 23, 2025, at 1:47 p.m., clinical nurse supervisor (CNS)-C stated they assisted LALD-D in creating resident service plans. CNS-C stated LALD-D could answer the questions related to the service plan. CNS-C asked LALD-D to join the interview.</p> <p>On September 23, 2025, at 1:52 p.m., licensed assisted living director (LALD)-D stated the licensee had two different service plans. The document titled Service Plan was the basic service plan all residents received at admission that included the contingency plan. LALD-D stated the licensee created an additional service plan titled Service/Care Plan once the county approved and provided rates for the resident's services. LALD-D stated the Service/Care plan was also provided to residents. LALD-D acknowledged how the different service plan lacked required information.</p> <p>The licensee's Service Plan Policy dated August 1, 2021, read, "2. Required Service Plan Content Each service plan must include, at minimum:</p> <ul style="list-style-type: none"> - Resident demographics and emergency contact information. - Contingency plan outlining how services will continue if normal staffing, resources, or systems are disrupted (e.g., during emergencies or evacuations). - Resident goals, strengths, and preferences. - Description of each service provided, including frequency, duration, and staff responsible. 	01650		
-------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2025
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER UNIQUE HOMES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4922 NEWTON AVENUE NORTH MINNEAPOLIS, MN 55430
-------------------------------------------------------------	----------------------------------------------------------------------------------------------------

(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	<p>Continued From page 34</p> <ul style="list-style-type: none"> - Provider contact information, including physicians, pharmacies, therapists, and other relevant healthcare professionals. - Fees for each service, consistent with the resident's contract and billing practices. - Medication management services (if applicable). - Treatments, therapies, or delegated nursing tasks (if applicable). - Risk factors, safety interventions, and any specialized care needs. - Documentation of resident choice, including the right to refuse care." <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	01650		
01710 SS=F	<p>144G.71 Subd. 3 Individualized medication monitoring and reas</p> <p>A registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed face-to-face medication management re-assessments at least annually for three of three residents (R1, R2, R4).</p>	01710		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2025
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER UNIQUE HOMES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4922 NEWTON AVENUE NORTH MINNEAPOLIS, MN 55430
-------------------------------------------------------------	----------------------------------------------------------------------------------------------------

(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
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	--------------------

01710	<p>Continued From page 35</p> <p>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).</p> <p>The findings include:</p> <p>R1 R1 admitted to the licensee on August 1, 2021, and began receiving assisted living services.</p> <p>R1's diagnoses included brain injury and unspecified psychosis (condition in which one is unable to distinguish, in one's own experience of life, between what is and is not real.)</p> <p>R1's record included two service plans.</p> <p>R1's Service Plan signed January 20, 2025, indicated, "see exhibit 1 for level of care and charges". R1's Service Plan lacked "exhibit 1". The service plan did not identify any services the licensee would provide to R1.</p> <p>R1's Service/Care Plan signed August 1, 2021, indicated R1 received assistance with appointments, shopping, homemaking, arranging non-medical transportation, meals, socialization, transportation, dressing, grooming, bathing, medication management, and behavior management.</p> <p>On September 23, 2025, at 8:18 a.m., the</p>	01710		
-------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2025
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER UNIQUE HOMES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4922 NEWTON AVENUE NORTH MINNEAPOLIS, MN 55430
-------------------------------------------------------------	----------------------------------------------------------------------------------------------------

(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
01710	<p>Continued From page 36</p> <p>surveyor observed unlicensed personnel (ULP)-A administer medication to R1.</p> <p>R1's Medication Assessment was completed on May 4, 2020.</p> <p>R1's Individualized medication Management Plan Sample Form dated January 20, 2025, indicated staff administered R1's medications. The document did not contain a medication assessment.</p> <p>R1's Medication Assessment for Safety in Self Administration dated January 25, 2025, assessed R1's ability to self-administer medication however did not contain the required content for a medication assessment.</p> <p>R1's ongoing assessment dated September 21, 2025, included a section titled Review of Medications (Prescriptions, Over the Counter, Supplments). The section included a place to write the name of the medication, indication, dosage, frequency, route, allergic reaction, side effects, contraindications, preferences, self-administration, and interventions to prevent diversions. This section was not filled in with R1's medication information.</p> <p>R2 R2 admitted to the licensee on August 7, 2020, under the licensee's previous comprehensive license and began receiving assisted living services on August 1, 2021.</p> <p>R2's diagnoses included schizoaffective disorder (mental health condition marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms,</p>	01710		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2025
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER UNIQUE HOMES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4922 NEWTON AVENUE NORTH MINNEAPOLIS, MN 55430
-------------------------------------------------------------	----------------------------------------------------------------------------------------------------

(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
01710	<p>Continued From page 37</p> <p>such as depression and mania), bipolar disorder (mental health condition that causes significant mood changes that can disrupt daily life), and neurocognitive disorder due to a traumatic brain injury.</p> <p>R2's record included two service plans.</p> <p>R2's Service Plan signed January 20, 2025, indicated, "see exhibit 1 for level of care and charges". R2's Service Plan lacked "exhibit 1". The service plan did not identify any services the licensee would provide to R2.</p> <p>R2's Service/Care Plan signed July 31, 2023, indicated R2 received assistance with homemaking, shopping, appointments, arranging non-medical appointments, socialization, meals, dressing, grooming, bathing, walking, medication management, and behavior management.</p> <p>R2's record lacked a Medication Assessment form.</p> <p>R2's Individualized medication Management Plan Sample Form dated January 20, 2025, indicated staff administered R2's medications. The document did not contain a medication assessment.</p> <p>R2's Medication Assessment for Safety in Self Administration dated January 20, 2025, assessed R2's ability to self-administer medication however did not contain the required content for a medication assessment.</p> <p>R2's ongoing assessment dated September 21, 2025, included a section titled Review of Medications (Prescriptions, Over the Counter,</p>	01710		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2025
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER UNIQUE HOMES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4922 NEWTON AVENUE NORTH MINNEAPOLIS, MN 55430
-------------------------------------------------------------	----------------------------------------------------------------------------------------------------

(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
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	--------------------

01710	<p>Continued From page 38</p> <p>Supplments). The section included a place to write the name of the medication, indication, dosage, frequency, route, allergic reaction, side effects, contraindications, preferences, self-administration, and interventions to prevent diversions. This section was not filled in with R2's medication information.</p> <p>R4 R4 admitted to the licensee on January 2, 2020, under the licensee's previous comprehensive license and began receiving assisted living services on August 1, 2021.</p> <p>R4's diagnoses included pancreatitis, dementia, low level literacy, and chemical dependency.</p> <p>R4's Service Plan signed January 20, 2025, indicated, "see exhibit 1 for level of care and charges". R4's Service Plan lacked "exhibit 1". The service plan did not identify any services the licensee would provide to R4.</p> <p>On September 23, 2025, at 9:15 a.m., the surveyor observed ULP-A administer medication to R4.</p> <p>R4's record lacked a Medication Assessment form.</p> <p>R4's Medication Assessment/Delegation Form dated November 11, 2022, included content for the medication plan however did not contain a medication assessment.</p> <p>R4's Individualized medication Management Plan Sample Form dated January 20, 2025, indicated staff administered R4's medications. The document did not contain a medication</p>	01710		
-------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2025
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER UNIQUE HOMES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4922 NEWTON AVENUE NORTH MINNEAPOLIS, MN 55430
-------------------------------------------------------------	----------------------------------------------------------------------------------------------------

(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
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	--------------------

01710	<p>Continued From page 39 assessment.</p> <p>R4's Medication Assessment for Safety in Self Administration dated November 11, 2022, assessed R4's ability to self-administer medication however did not contain the required content for a medication assessment.</p> <p>R4's ongoing assessment dated September 21, 2025, included a section titled Review of Medications (Prescriptions, Over the Counter, Supplments). The section included a place to write the name of the medication, indication, dosage, frequency, route, allergic reaction, side effects, contraindications, preferences, self-administration, and interventions to prevent diversions. This section was not filled in with R4's medication information.</p> <p>R1, R2, and R4's medical record lacked a yearly medication assessment that include an identification and review of all medications the resident was known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues.</p> <p>On September 23, 2025, at 1:17 p.m., clinical nurse supervisor (CNS)-C stated their assessments contained the medication assessment however, they did not fill in the section in the assessment for R1, R2, and R4 in the past year. CNS-C stated they did not know the medication assessment needed to be completed yearly.</p> <p>The licensee's Medication Management Policy Dated August 1, 2021, read, "All medication</p>	01710		
-------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2025
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER UNIQUE HOMES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4922 NEWTON AVENUE NORTH MINNEAPOLIS, MN 55430
-------------------------------------------------------------	----------------------------------------------------------------------------------------------------

(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
01710	Continued From page 40 management will be carried out in compliance with Minnesota Statutes, Chapter 144G, MDH rules, and the Minnesota Nurse Practice Act." In addition, the registered nurse (RN) would review resident's medications, MAR, and administration practices at least every 90 days or with change of condition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis;	01730		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2025
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER UNIQUE HOMES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4922 NEWTON AVENUE NORTH MINNEAPOLIS, MN 55430
-------------------------------------------------------------	----------------------------------------------------------------------------------------------------

(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
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	--------------------

01730	<p>Continued From page 41</p> <p>(5) identification of medication management tasks that may be delegated to unlicensed personnel;</p> <p>(6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and</p> <p>(7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions.</p> <p>(b) The medication management record must be current and updated when there are any changes.</p> <p>(c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain an accurate individualized medication management record for one of three residents (R1).</p> <p>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).</p>	01730		
-------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2025
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER UNIQUE HOMES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4922 NEWTON AVENUE NORTH MINNEAPOLIS, MN 55430
-------------------------------------------------------------	----------------------------------------------------------------------------------------------------

(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
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	--------------------

01730	<p>Continued From page 42</p> <p>The findings include:</p> <p>R1 admitted to the licensee on August 1, 2021, and began receiving assisted living services.</p> <p>R1's diagnoses included brain injury and unspecified psychosis (condition in which one is unable to distinguish, in one's own experience of life, between what is and is not real.)</p> <p>R1's record included two service plans.</p> <p>R1's Service Plan signed January 20, 2025, indicated, "see exhibit 1 for level of care and charges". R1's Service Plan lacked "exhibit 1". The service plan did not identify any services the licensee would provide to R1.</p> <p>R1's Service/Care Plan signed August 1, 2021, indicated R1 received assistance with appointments, shopping, homemaking, arranging non-medical transportation, meals, socialization, transportation, dressing, grooming, bathing, medication management, and behavior management.</p> <p>On September 23, 2025, at 8:18 a.m., the surveyor observed unlicensed personnel (ULP)-A administer oral and subcutaneous (SQ) medication to R1. After administration of the oral and SQ medication, ULP-A documented the oral and SQ medication as being administered on the medication administration record (MAR). In addition, ULP-A also documented the following topical medications as being administered on the MAR:</p> <ul style="list-style-type: none"> - urea cream 40 percent (%) to dry skin; - triamcinolone acetate cream 0.1 % to the labia; <p>and</p>	01730		
-------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2025
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER UNIQUE HOMES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4922 NEWTON AVENUE NORTH MINNEAPOLIS, MN 55430
-------------------------------------------------------------	----------------------------------------------------------------------------------------------------

(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
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	--------------------

01730	<p>Continued From page 43</p> <p>- ammonium lactate cream 12% to both feet. The surveyor observed no creams in R1's medication box or the medication closet.</p> <p>On September 23, 2025, at 9:23 a.m., ULP-A stated the creams listed above were administered around 7:00 a.m. ULP-A stated the creams listed above were stored in R1's room.</p> <p>R1's Individualized medication Management Plan Sample Form dated January 20, 2025, indicated staff administered R1's medications, medications were stored in a locked medication room, and ULP could administer topical medications.</p> <p>R1's Medication Assessment for Safety in Self Administration dated January 25, 2025, assessed R1's ability to self-administer medications and determined R1 was deemed unable to safely self-administer medications and medications were to be managed by facility nurse and staff.</p> <p>R1's ongoing assessment dated September 21, 2025, indicated R1 was deemed unable to safely self-administer medications for the following reasons:</p> <ul style="list-style-type: none"> - orientation issues; - forgetfulness; and - mental health. <p>R1's individualized medication management plan comprised of multiple documents did not accurately reflect R1's storage of medication, and R1's ability to self-administer topical medicated creams.</p> <p>On September 23, 2025, at 9:38 a.m., clinical nurse supervisor (CNS)-C stated R1's creams were kept in R1's room because they wanted to</p>	01730		
-------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2025
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER UNIQUE HOMES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4922 NEWTON AVENUE NORTH MINNEAPOLIS, MN 55430
-------------------------------------------------------------	----------------------------------------------------------------------------------------------------

(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
01730	<p>Continued From page 44</p> <p>apply them independently and then would let the staff know once they applied them.</p> <p>On September 23, 2025, at 9:43 a.m., the surveyor showed CNS-C multiple areas within R1's medical record that indicated all medication was stored by the licensee. CNS-C stated "it was just an oversight" that the documents were marked that way.</p> <p>The licensee's Medication Management Policy Dated August 1, 2021, read, "All medication management will be carried out in compliance with Minnesota Statutes, Chapter 144G, MDH rules, and the Minnesota Nurse Practice Act." In addition, residents may self-administer medications if determined safe by the registered nurse (RN) and documented in the service plan.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	01730		
01760 SS=E	<p>144G.71 Subd. 8 Documentation of administration of medication</p> <p>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 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</p>	01760		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2025
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER UNIQUE HOMES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4922 NEWTON AVENUE NORTH MINNEAPOLIS, MN 55430
-------------------------------------------------------------	----------------------------------------------------------------------------------------------------

(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
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	--------------------

01760	<p>Continued From page 45</p> <p>administered as prescribed and in compliance with the resident's medication management plan.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to document medication administration timely and accurately for one of two residents (R1) observed. In addition, the licensee failed to document as needed (PRN) medication effectiveness for one of three residents (R1) and failed to document the reason why medications were not administered for one of three residents (R2).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).</p> <p>The findings include:</p> <p>R1 R1 admitted to the licensee on August 1, 2021, and began receiving assisted living services.</p> <p>R1's diagnoses included brain injury and unspecified psychosis (condition in which one is unable to distinguish, in one's own experience of life, between what is and is not real.)</p> <p>R1's record included two service plans.</p>	01760		
-------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2025
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER UNIQUE HOMES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4922 NEWTON AVENUE NORTH MINNEAPOLIS, MN 55430
-------------------------------------------------------------	----------------------------------------------------------------------------------------------------

(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
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	--------------------

01760	<p>Continued From page 46</p> <p>R1's Service Plan signed January 20, 2025, indicated, "see exhibit 1 for level of care and charges". R1's Service Plan lacked "exhibit 1". The service plan did not identify any services the licensee would provide to R1.</p> <p>R1's Service/Care Plan signed August 1, 2021, indicated R1 received assistance with appointments, shopping, homemaking, arranging non-medical transportation, meals, socialization, transportation, dressing, grooming, bathing, medication management, and behavior management.</p> <p>TIMELY DOCUMENTATION/ACCURATE DOCUMENTATION On September 23, 2025, at 8:18 a.m., the surveyor observed unlicensed personnel (ULP)-A administer benzotropine 1 milligram (mg), daily-vite one tablet, escitalopram 20 mg, metformin extended release (ER) 500 mg, and three unidentified pills that were set up in a Medi planner. After the medication was administered, ULP-A retrieved a medication boxe from the medication closet and set up and administered Saxedena 3 mg subcutaneous (SQ) for R1. ULP-A then retrieved a locked narcotic box and administered clonazepam 0.5 mg medication to R1. At 8:54 a.m., ULP-A documented the oral and SQ medication listed above as being administered on the medication administration record (MAR). In addition, ULP-A documented the following medications as being administered on the MAR:</p> <ul style="list-style-type: none"> - urea cream 40 percent (%) to dry skin; - triamcinolone acetate cream 0.1 % to the labia; and - ammonium lactate cream 12% to both feet; - olopatadine 0.2% eye drop; and 	01760		
-------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2025
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER UNIQUE HOMES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4922 NEWTON AVENUE NORTH MINNEAPOLIS, MN 55430
-------------------------------------------------------------	----------------------------------------------------------------------------------------------------

(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
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	--------------------

01760	<p>Continued From page 47</p> <p>- lubricant eye drop 0.5 %.</p> <p>The surveyor did not observe ULP-A administer urea cream, triamcinolone acetate cream, ammonium lactate cream, olopatadine eye drop, and lubricant eye drop.</p> <p>On September 23, 2025, at 9:23 a.m., ULP-A stated the creams were administered around 7:00 a.m. ULP-A stated they documented in the MAR once all medications were administered for R1. ULP-A stated they were trained to make sure the resident took all the medication before documenting, however, ULP-A stated R1's eye drops were discontinued. The surveyor inquired why their documentation indicated R1 received the eye drops. ULP-A stated they were going to go back and place a circle around the eye drops (to indicate they had not been administered) and had not gotten to it. The surveyor inquired if ULP-A administered eye drops on September 22, 2025. ULP-A stated they did not administer eye drops to R1. The surveyor inquired why the documentation showed they administered eye drops on September 22, 2025. ULP-A stated they forgot to circle the medications.</p> <p>On September 23, 2025, at 9:38 a.m., clinical nurse supervisor (CNS)-C stated R1 told them their eye drops were discontinued on September 19, 2025. CNS-C stated the eye drops were not removed from the MAR because they were waiting on a discontinuation order from the prescriber or pharmacy. CNS-C stated they did not have R1's eye drops at the facility.</p> <p>On September 23, 2025, at 1:29 p.m., CNS-C stated ULP were trained to document on medication administration "right away" after the medication was received.</p>	01760		
-------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2025
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER UNIQUE HOMES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4922 NEWTON AVENUE NORTH MINNEAPOLIS, MN 55430
-------------------------------------------------------------	----------------------------------------------------------------------------------------------------

(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
01760	<p>Continued From page 48</p> <p>The licensee's 2.38 Documentation Requirement Policy dated August 1, 2021, indicated documentation must be entered contemporaneously with the event or service provided or as soon as possible thereafter.</p> <p>The licensee's Medication Management Policy Dated August 1, 2021, read, "All medication management will be carried out in compliance with Minnesota Statutes, Chapter 144G, MDH rules, and the Minnesota Nurse Practice Act." In addition, all medication must be recorded on the MAR immediately after administration.</p> <p>EFFECTIVENESS OF MEDICATION R1's MAR dated September 1, 2025, through September 31, 2025, included an order for diphenhydramine 50 mg capsule administer one capsule at bedtime PRN for insomnia. The MAR indicated R1 received diphenhydramine 16 times in the month of September. The MAR lacked documentation if the medication was effective or ineffective for R1's insomnia.</p> <p>R1's progress notes dated September 4, 2025, through September 17, 2025, did not include information on the effectiveness of diphenhydramine when administered to R1.</p> <p>On September 23, 2025, at 1:29 p.m., CNS-C stated for PRN medications, ULP were trained once the medication was given, they were to write their initials on the MAR and on the back of the MAR document why the medication was given and if the medication was effective.</p> <p>The licensee's Medication Management Policy Dated August 1, 2021, read, "All medication</p>	01760		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2025
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER UNIQUE HOMES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4922 NEWTON AVENUE NORTH MINNEAPOLIS, MN 55430
-------------------------------------------------------------	----------------------------------------------------------------------------------------------------

(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
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	--------------------

01760	<p>Continued From page 49</p> <p>management will be carried out in compliance with Minnesota Statutes, Chapter 144G, MDH rules, and the Minnesota Nurse Practice Act." In addition, the documentation must include the date, time, medication, dose, route, staff initials/signature, and resident response.</p> <p>DOCUMENTATION TO WHY A MEDICATION WAS NOT ADMINISTERED</p> <p>R2 R2 admitted to the licensee on August 7, 2020, under the licensee's previous comprehensive license and began receiving assisted living services on August 1, 2021.</p> <p>R2's diagnoses included schizoaffective disorder (mental health condition marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as depression and mania), bipolar disorder (mental health condition that causes significant mood changes that can disrupt daily life), and neurocognitive disorder due to a traumatic brain injury.</p> <p>R2's record included two service plans.</p> <p>R2's Service Plan signed January 20, 2025, indicated, "see exhibit 1 for level of care and charges". R2's Service Plan lacked "exhibit 1". The service plan did not identify any services the licensee would provide to R2.</p> <p>R2's Service/Care Plan signed July 31, 2023, indicated R2 received assistance with homemaking, shopping, appointments, arranging non-medical appointments, socialization, meals, dressing, grooming, bathing, walking, medication management, and behavior management.</p>	01760		
-------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2025
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER UNIQUE HOMES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4922 NEWTON AVENUE NORTH MINNEAPOLIS, MN 55430
-------------------------------------------------------------	----------------------------------------------------------------------------------------------------

(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
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	--------------------

01760	<p>Continued From page 50</p> <p>R2's MAR included folic acid 1 mg tablet daily, vitamin B1-100 mg daily, olanzapine 10 mg twice per day, divalproex sodium 500 mg delayed release (DR) twice per day, and gabapentin 300 mg three times per day. The MAR indicated the following:</p> <ul style="list-style-type: none"> - gabapentin 300 mg was not administered in afternoon on September 1, 2025; - gabapentin 300 mg, and olanzapine 10 mg were not administered at bedtime on September 4, 2025; and - gabapentin 300 mg, divalproex sodium 500 mg ER, olanzapine 10 mg, vitamin B1, daily-vite one tablet, and folic acid 1mg were not administered on September 1, 2025. <p>The MAR did not indicate why R2 did not receive the medications.</p> <p>On September 23, 2025, at 1:29 p.m., CNS-C stated a circled initial on the MAR indicated a resident refused a medication or a resident was not present at the facility during the medication pass. CNS-C stated ULP were trained once they circle their initial on the MAR to go to the back of the MAR and write the reason why the medication was not administered.</p> <p>The licensee's Medication Management Policy Dated August 1, 2021, read, "All medication management will be carried out in compliance with Minnesota Statutes, Chapter 144G, MDH rules, and the Minnesota Nurse Practice Act." In addition, medications refusals, errors, or omissions must be documented with an explanation and reported to the RN and LALD. The LALD would conduct monthly audits of medication documentation.</p>	01760		
-------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2025
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER UNIQUE HOMES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4922 NEWTON AVENUE NORTH MINNEAPOLIS, MN 55430
-------------------------------------------------------------	----------------------------------------------------------------------------------------------------

(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
01760	Continued From page 51 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01790 SS=D	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's	01790		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2025
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER UNIQUE HOMES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4922 NEWTON AVENUE NORTH MINNEAPOLIS, MN 55430
-------------------------------------------------------------	----------------------------------------------------------------------------------------------------

(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
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	--------------------

01790	<p>Continued From page 52</p> <p>medication system;</p> <p>(ii) how the container or containers must be labeled;</p> <p>(iii) written information about the medications to be provided;</p> <p>(iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information;</p> <p>(v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative;</p> <p>(vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and</p> <p>(vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) developed training and competencies for unlicensed personnel (ULP) providing medications to residents for unplanned time away from home when the licensed nurse was not available for one of two employees (ULP)-A).</p> <p>This practice resulted in a level two violation (a</p>	01790		
-------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2025
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER UNIQUE HOMES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4922 NEWTON AVENUE NORTH MINNEAPOLIS, MN 55430
-------------------------------------------------------------	----------------------------------------------------------------------------------------------------

(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
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	--------------------

01790	<p>Continued From page 53</p> <p>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).</p> <p>The findings include:</p> <p>On February 15, 2023, the licensee received results from the previous survey concluded on January 6, 2023. The longest time period for correction (the time frame the licensee must document and correct orders) was 21 days from the date the licensee received their results, which was March 8, 2023. The licensee's correction orders included tag identifier 1790 related to medication management for residents who will be away from home.</p> <p>The licensee's corrective actions dated January 26, 2023, from the previous survey completed January 6, 2023, included:</p> <ul style="list-style-type: none"> - written instruction provided for resident absences; - staff re-trained on medication procedures; - competency evaluations were completed annually; and - quarterly medication audits by registered nurse (RN). <p>ULP-A was hired on June 5, 2024, to provide assisted living services.</p> <p>ULP-A's employee record lacked documentation of training and a competency evaluation for unplanned time away from home.</p>	01790		
-------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2025
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER UNIQUE HOMES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4922 NEWTON AVENUE NORTH MINNEAPOLIS, MN 55430
-------------------------------------------------------------	----------------------------------------------------------------------------------------------------

(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
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	--------------------

01790	<p>Continued From page 54</p> <p>On September 22, 2025, at 11:53 a.m., ULP-A stated residents would let staff know when they were leaving the facility, and the nurse would come in and set up the medication for them to take with them. ULP-A said the nurse was not always there when the medications were given to the resident. ULP-A stated if they need to provide medication to the resident the nurse would train them and walk them through it. ULP-A stated they had not been trained on how to prepare medication for time away from home.</p> <p>On September 23, 2025, at 2:00 p.m., licensed assisted living director (LALD)-D stated ULP-A did not have training or a competency for time away from home medication set up. LALD-D stated they were going to contact EduCare (a training software) to have them add the training to their list.</p> <p>On September 24, 2025, at 9:59 a.m., clinical nurse supervisor (CNS)-C stated the staff contact them when a resident wants to leave the facility with medication, and stated they would come to the facility to set up the medication. CNS-C stated they either provided the medication to the responsible party or the staff will provide the set up medications and then document when it was provided. CNS-C stated medications were not given to residents deemed not appropriate to self-administer and for those residents, they would leave the facility and return for medication administration.</p> <p>The licensee's Content of Employee Records policy dated August 1, 2021, read, "[the licensee] maintains complete, accurate, and confidential employee records for all staff. Records are kept</p>	01790		
-------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2025
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER UNIQUE HOMES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4922 NEWTON AVENUE NORTH MINNEAPOLIS, MN 55430
-------------------------------------------------------------	----------------------------------------------------------------------------------------------------

(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
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	--------------------

01790	<p>Continued From page 55</p> <p>in accordance with Minnesota Statutes, Chapter 144G, the Minnesota Department of Health (MDH) regulations, and other applicable employment laws. Documentation in employee records supports regulatory compliance, staff competency, and resident safety." In addition, the employee record would include training and competency evaluations.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	01790		
01820 SS=E	<p>144G.71 Subd. 13 Prescriptions</p> <p>There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for two of three residents (R1, R2).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).</p>	01820		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2025
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER UNIQUE HOMES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4922 NEWTON AVENUE NORTH MINNEAPOLIS, MN 55430
-------------------------------------------------------------	----------------------------------------------------------------------------------------------------

(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
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	--------------------

01820	<p>Continued From page 56</p> <p>The findings include:</p> <p>R1 R1 admitted to the licensee on August 1, 2021, and began receiving assisted living services.</p> <p>R1's diagnoses included brain injury and unspecified psychosis (condition in which one is unable to distinguish, in one's own experience of life, between what is and is not real.)</p> <p>R1's record included two service plans.</p> <p>R1's Service Plan signed January 20, 2025, indicated, "see exhibit 1 for level of care and charges". R1's Service Plan lacked "exhibit 1". The service plan did not identify any services the licensee would provide to R1.</p> <p>R1's Service/Care Plan signed August 1, 2021, indicated R1 received assistance with appointments, shopping, homemaking, arranging non-medical transportation, meals, socialization, transportation, dressing, grooming, bathing, medication management, and behavior management.</p> <p>On September 23, 2025, at 8:18 a.m., the surveyor observed unlicensed personnel (ULP)-A administer medications to R1 that included metformin extended release (ER) 500 milligrams (mg).</p> <p>R1's medication administration record (MAR) dated September 1, 2025, through September 31, 2025, included metformin extended release (ER) 500 mg twice per day with meals, retin-a cream 0.25 percent (%) apply nightly, and</p>	01820		
-------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2025
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER UNIQUE HOMES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4922 NEWTON AVENUE NORTH MINNEAPOLIS, MN 55430
-------------------------------------------------------------	----------------------------------------------------------------------------------------------------

(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
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	--------------------

01820	<p>Continued From page 57</p> <p>clobetasol 0.5 % cream apply twice per day as needed (PRN).</p> <p>R1's After Visit Summary (AVS) dated September 17, 2025, included metformin 500 mg take twice per day. The order lacked a prescriber's signature. In addition, the AVS did not include retin-a cream or clobetasol cream.</p> <p>R1's record lacked a prescriber order for metformin ER 500 mg twice per day with meals, retin-a cream 0.25 % apply nightly, and clobetasol 0.5 % apply twice per day PRN.</p> <p>R2 R2 admitted to the licensee on August 7, 2020, under the licensee's previous comprehensive license and began receiving assisted living services on August 1, 2021.</p> <p>R2's diagnoses included schizoaffective disorder (mental health condition marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as depression and mania), bipolar disorder (mental health condition that causes significant mood changes that can disrupt daily life), and neurocognitive disorder due to a traumatic brain injury.</p> <p>R2's record included two service plans.</p> <p>R2's Service Plan signed January 20, 2025, indicated, "see exhibit 1 for level of care and charges". R2's Service Plan lacked "exhibit 1". The service plan did not identify any services the licensee would provide to R2.</p> <p>R2's Service/Care Plan signed July 31, 2023,</p>	01820		
-------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2025
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER UNIQUE HOMES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4922 NEWTON AVENUE NORTH MINNEAPOLIS, MN 55430
-------------------------------------------------------------	----------------------------------------------------------------------------------------------------

(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
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	--------------------

01820	<p>Continued From page 58</p> <p>indicated R2 received assistance with homemaking, shopping, appointments, arranging non-medical appointments, socialization, meals, dressing, grooming, bathing, walking, medication management, and behavior management.</p> <p>R2's MAR dated September 1, 2025, through September 31, 2025, included nicotine gum 4 mg chew one piece slowly and intermittently for 30 minutes may repeat every one to two hours PRN, and oxycodone 5 mg PRN twice per day.</p> <p>R1's record lacked a prescriber's order for oxycodone and nicotine gum.</p> <p>On September 23, 2025, at 9:46 a.m., clinical nurse supervisor (CNS)-C stated R1's metformin was decreased from 1000 mg to 500 mg, and they were unable to locate the signed order. CNS-C stated metformin 500 mg was listed on the AVS they recently received. CNS-C stated they were unable to locate the rentin-a cream or clobetasol cream prescriber order.</p> <p>On September 23, 2025, at 1:17 p.m., CNS-C stated R2's nicotine and oxycodone had been discontinued and had not been at the facility since they started working for the licensee in 2024. The surveyor inquired if they had a discontinuation order. CNS-C stated since they have been the nurse they have not received a discontinuation order for nicotine or oxycodone. The surveyor inquired why the medications were not removed off the MAR. CNS-C stated they did not know why.</p> <p>The licensee's Medication Management Policy Dated August 1, 2021, read, "All medication management will be carried out in compliance</p>	01820		
-------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2025
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER UNIQUE HOMES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4922 NEWTON AVENUE NORTH MINNEAPOLIS, MN 55430
-------------------------------------------------------------	----------------------------------------------------------------------------------------------------

(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
01820	Continued From page 59 with Minnesota Statutes, Chapter 144G, MDH rules, and the Minnesota Nurse Practice Act." In addition, medications would only be given with a valid written order from a licensed prescriber. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01830 SS=D	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure prescriptions were renewed at least every 12 months for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 admitted to the licensee on August 7, 2020, under the licensee's previous comprehensive	01830		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2025
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER UNIQUE HOMES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4922 NEWTON AVENUE NORTH MINNEAPOLIS, MN 55430
-------------------------------------------------------------	----------------------------------------------------------------------------------------------------

(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
01830	<p>Continued From page 60</p> <p>license and began receiving assisted living services on August 1, 2021.</p> <p>R2's diagnoses included schizoaffective disorder (mental health condition marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as depression and mania), bipolar disorder (mental health condition that causes significant mood changes that can disrupt daily life), and neurocognitive disorder due to a traumatic brain injury.</p> <p>R2's record included two service plans.</p> <p>R2's Service Plan signed January 20, 2025, indicated, "see exhibit 1 for level of care and charges". R2's Service Plan lacked "exhibit 1". The service plan did not identify any services the licensee would provide to R2.</p> <p>R2's Service/Care Plan signed July 31, 2023, indicated R2 received assistance with homemaking, shopping, appointments, arranging non-medical appointments, socialization, meals, dressing, grooming, bathing, walking, medication management, and behavior management.</p> <p>R2's Medication Administration Record (MAR) dated September 1, 2025, through September 31, 2025, included folic acid 1 milligram (mg) daily, and daily-vite tablet one tablet daily. The MAR indicated staff administered the medication 20 times in the month of September.</p> <p>R2's After Visit Summary (AVS) dated March 3, 2023, included folic acid 1 mg daily and daily multivitamin 1 tablet daily.</p>	01830		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2025
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER UNIQUE HOMES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4922 NEWTON AVENUE NORTH MINNEAPOLIS, MN 55430
-------------------------------------------------------------	----------------------------------------------------------------------------------------------------

(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
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	--------------------

01830	<p>Continued From page 61</p> <p>R2's medical record lacked prescriber's orders for folic acid 1 mg daily and daily-vite 1 tablet daily issued within the past year.</p> <p>On September 23, 2025, at 1:22 p.m., clinical nurse supervisor (CNS)-C stated the pharmacy sends the licensee prescriber orders once they are received or the prescriber will send the order on an AVS. CNS-C stated the AVS dated March 2, 2023, was the most recent order they could locate for folic acid and daily-vite.</p> <p>On September 24, 2024, at 9:59 a.m., CNS-C stated orders should be renewed yearly and "maybe" with change to the medications.</p> <p>The licensee's Medication Management Policy Dated August 1, 2021, read, "All medication management will be carried out in compliance with Minnesota Statutes, Chapter 144G, MDH rules, and the Minnesota Nurse Practice Act." In addition, medications would only be given with a valid written order from a licensed prescriber.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	01830		
01880 SS=F	<p>144G.71 Subd. 19 Storage of medications</p> <p>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.</p> <p>This MN Requirement is not met as evidenced by:</p>	01880		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2025
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER UNIQUE HOMES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4922 NEWTON AVENUE NORTH MINNEAPOLIS, MN 55430
-------------------------------------------------------------	----------------------------------------------------------------------------------------------------

(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	<p>Continued From page 62</p> <p>Based on observation, interview, and record review, the licensee failed to store prescription medication securely to permit only authorized personnel to have access.</p> <p>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).</p> <p>The findings include:</p> <p>On September 22, 2025, at 11:03 a.m., the surveyor observed the licensee's unlocked kitchen refrigerator and observed two boxes of Saxenda 18 milligram (mg)/ 3 militer (ml) pens for R1 and risperdone 50 mg/vial single dose pack for R2 unsecured. Clinical nurse supervisor (CNS)-C stated the risperdone box would not fit in the licensee's current refrigerated locked box and they did not know the other two medications were in the kitchen refrigerator.</p> <p>The licensee's Medication Management Policy Dated August 1, 2021, read, "All medication management will be carried out in compliance with Minnesota Statutes, Chapter 144G, MDH rules, and the Minnesota Nurse Practice Act." In addition, refrigerated medications would be stored in a dedicated locked refrigerator with temperature logs maintained daily. The LALD [licensed assisted living director] would conduct monthly audits of medication storage.</p>	01880		
-------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2025
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER UNIQUE HOMES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4922 NEWTON AVENUE NORTH MINNEAPOLIS, MN 55430
-------------------------------------------------------------	----------------------------------------------------------------------------------------------------

(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 63 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=D	<p>144G.71 Subd. 20 Prescription drugs</p> <p>A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to discard expired medication for one of three residents (R2).</p> <p>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).</p> <p>The findings include:</p> <p>On September 22, 2025, at 11:03 a.m., the surveyor observed the licensee's locked medication box located in the kitchen refrigerator. The surveyor observed the following: - Two boxes of Risperdal Consta 50 milligram (mg)/ 2 milter (ml) with an expiration date of</p>	01890		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2025
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER UNIQUE HOMES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4922 NEWTON AVENUE NORTH MINNEAPOLIS, MN 55430
-------------------------------------------------------------	----------------------------------------------------------------------------------------------------

(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
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	--------------------

01890	<p>Continued From page 64</p> <p>October 12, 2023, and November 9, 2023, which belonged to R2. Clinical nurse supervisor (CNS)-C stated they did not know the medication was in the locked box and that was why they were not disposed.</p> <p>The licensee's Medication Management Policy Dated August 1, 2021, read, "All medication management will be carried out in compliance with Minnesota Statutes, Chapter 144G, MDH rules, and the Minnesota Nurse Practice Act." In addition, discontinued or expired medications would be disposed of according to state and federal law.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	01890		
-------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--



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

Food & Beverage Inspection Report

Page: 1

Establishment Info	License Info	Inspection Info
UNIQUE HOMES LLC 4922 NEWTON AVENUE NORTH Minneapolis, MN 55430 Hennepin County Parcel: Phone:	License: HFID 35310 Risk: License: Expires on: CFPM: John Merchant CFPM #: CFPM-59981; Exp: 6/6/2028	Report Number: F1039251136 Inspection Type: Full - Single Date: 9/23/2025 Time: 11:00:00 Duration: minutes Announced Inspection: <u>Total Priority 1 Orders: 0</u> <u>Total Priority 2 Orders: 2</u> <u>Total Priority 3 Orders: 2</u> <u>Delivery: Emailed</u>

New Order: 4-300 Equipment Numbers and Capacities

4-302.13B *Priority Level: Priority 2 CFP#: 48*

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

COMMENT: NO MEASURING DEVICE ON-HAND FOR DISHWASHING MACHINE HOT WATER. PERSON-IN-CHARGE STATES THERMO TEST STRIPS ARE ON ORDER.

Comply By: 9/23/2025 Originally Issued On: 9/23/2025

New Order: 4-500 Equipment Maintenance and Operation

4-501.11AB *Priority Level: Priority 3 CFP#: 47*

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

COMMENT: HAND TOUCH POINTS OF KITCHEN CABINETS ARE WORN, NOT EASILY CLEANABLE. REFINISH WORN PORTION OF CABINETS SO THEY ARE SMOOTH, DURABLE, EASILY CLEANABLE.

LAMINATED FINISH MISSING ON COUNTERTOP EDGE IN KITCHEN. REFINISH ANY MISSING LAMINATED FINISH OR REPLACE COUNTERTOP TO GIVE SMOOTH, DURABLE, EASILY CLEANABLE SURFACES.

Comply By: 10/10/2025 Originally Issued On: 9/23/2025

New Order: 4-600 Cleaning Equipment and Utensils

4-601.11C *Priority Level: Priority 3 CFP#: 49*

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

COMMENT: HAND TOUCH POINTS ON KITCHEN CABINETRY HAS WEAR AND ACCUMULATED SOILS. AFTER REFINISHING, CLEAN AND MAINTAIN CLEAN.

Comply By: 10/10/2025 Originally Issued On: 9/23/2025

New Order: 6-300 Physical Facility Numbers and Capacities

6-301.11 *Priority Level: Priority 2 CFP#: 10*

MN Rule 4626.1440 Provide an adequate supply of hand soap at each handwashing sink or group of 2 adjacent handwashing sinks.

COMMENT: HAND SOAP PUMP IS BROKEN. PROVIDE NEW SOAP PUMP.

Comply By: 9/23/2025 Originally Issued On: 9/23/2025

Food & Beverage General Comment

AMBIENT - REFRIGERATOR - 40 DEGREES F

FREEZERS - FROZEN

The inspection was completed with the person in charge and reviewed with MDH HRD nurse evaluator Ashley Crews

The kitchen is of residential build and should serve food for same-day service only. Kitchen equipment and facilities show signs of wear, see orders.

A 2-compartment sink is present in kitchen. 1 compartment is designated for handwashing only.

Discussed the following with the person-in-charge: minimum cook temps for animal proteins, food source, foodborne illness symptoms and exclusion of ill employees, avoiding bare hand contact with ready to eat foods, handwashing, sanitizing., all orders on this report.

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 F1039251136 from 9/23/2025



John Merchant
person-in-charge

Aron Goodner,
Public Health Sanitarian 1
651-201-4910
aron.goodner@state.mn.us



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

Sanitizer Observations/Recordings

Page: 1

Establishment Info

UNIQUE HOMES LLC
Minneapolis
County/Group: Hennepin County

Inspection Info

Report Number: F1039251136
Inspection Type: Full
Date: 9/23/2025
Time: 11:00:00

Sanitizing Equipment: Product: Hot Water; **Sanitizing Process:** Dish Machine

Location: Equal To 160 Degrees F.

Comment: BY THERMO TEST STRIP

Violation Issued?: No