



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered

July 9, 2025

Licensee  
Family Choice Assisted Living LLC  
272 Arlington Avenue West  
Saint Paul, MN 55117

RE: Project Number(s) SL38908016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 15, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

### **STATE CORRECTION ORDERS**

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

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

### **DOCUMENTATION OF ACTION TO COMPLY**

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the

resident(s)/employee(s) identified in the correction order.

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

### **CORRECTION ORDER RECONSIDERATION PROCESS**

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

To submit a reconsideration request, please visit:

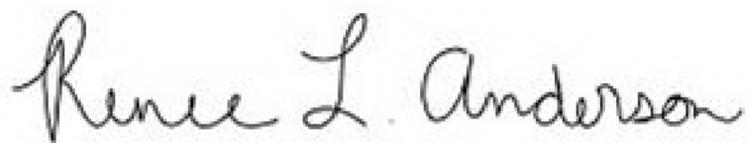
**<https://forms.web.health.state.mn.us/form/HRDAppealsForm>**

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



Renee Anderson, Supervisor

State Evaluation Team

Email: [Renee.L.Anderson@state.mn.us](mailto:Renee.L.Anderson@state.mn.us)

Telephone: 651-201-5871 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>38908</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/15/2025</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>FAMILY CHOICE ASSISTED LIVING LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>272 ARLINGTON AVENUE WEST SAINT PAUL, MN 55117</b>
--	--

(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><b>Initial Comments</b></p> <p><b>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)</b></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><b>INITIAL COMMENTS:</b></p> <p>SL38908016-0</p> <p>On May 12, 2025, through May 15, 2025, the Minnesota Department of Health conducted a full survey at the above provider, and the following orders are issued. At the time of the survey, there were three residents; three receiving services under the Provisional Assisted Living Facility license.</p>	0 000	<p>Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction.</p> <p><b>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.</b></p> <p><b>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level pursuant to 144G.31 Subd. 1, 2 and 3.</b></p>	
0 480 SS=F	<p><b>144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services</b></p> <p>(a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter</p>	0 480		

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:  <b>38908</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/15/2025</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>FAMILY CHOICE ASSISTED LIVING LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>272 ARLINGTON AVENUE WEST SAINT PAUL, MN 55117</b>
--	--

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>38908</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/15/2025</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>FAMILY CHOICE ASSISTED LIVING LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>272 ARLINGTON AVENUE WEST SAINT PAUL, MN 55117</b>
--	--

(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 2</p> <p>4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door.</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 May 12, 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		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>38908</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/15/2025</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>FAMILY CHOICE ASSISTED LIVING LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>272 ARLINGTON AVENUE WEST SAINT PAUL, MN 55117</b>
--	--

(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 3	0 680		
0 680 SS=F	<p><b>144G.42 Subd. 10 Disaster planning and emergency preparedness</b></p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by:                      Based on observation, interview, and record review the licensee failed to have a written emergency disaster preparedness plan with all the required content. This had the potential to affect all three 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</p>	0 680		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>38908</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/15/2025</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>FAMILY CHOICE ASSISTED LIVING LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>272 ARLINGTON AVENUE WEST SAINT PAUL, MN 55117</b>
--	--

(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 4</p> <p>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, last reviewed January 28, 2025, lacked evidence of the following required content: - an EP training and testing program to include a second annual full-scale exercise that is community based.</p> <p>On May 13, 2025, at 10:20 a.m., housing manager (HM)-A verified the licensee did not participate in a second annual full-scale exercise for 2024, but stated the facility employees participated in a table top disaster drill. HM-A stated they would ensure the annual full-scale exercise is completed in 2025.</p> <p>The licensee's Emergency Preparedness policy, dated September 29, 2022, indicated a disaster drill "is conducted at the residence at least annually. Results of the drill will be documented. the emergency preparedness plan/program will be reviewed/updated at least annually."</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	0 680		
0 810 SS=E	144G.45 Subd. 2 (b-f) Fire protection and physical environment	0 810		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>38908</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/15/2025</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>FAMILY CHOICE ASSISTED LIVING LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>272 ARLINGTON AVENUE WEST SAINT PAUL, MN 55117</b>
--	--

(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 5</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"> <li>(1) location and number of resident sleeping rooms;</li> <li>(2) staff actions to be taken in the event of a fire or similar emergency;</li> <li>(3) fire protection procedures necessary for residents; and</li> <li>(4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation.</li> </ul> <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 record review and interview, the licensee failed to develop the fire safety and evacuation plan with required content and provide required training.</p>	0 810		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>38908</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/15/2025</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>FAMILY CHOICE ASSISTED LIVING LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>272 ARLINGTON AVENUE WEST SAINT PAUL, MN 55117</b>
--	--

(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 6</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>On May 15, 2025, housing manager (HM)-A and clinical nurse supervisor (CNS)-B provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility.</p> <p><b>FIRE SAFETY AND EVACUATION PLAN</b> Record review of the available documentation indicated the licensee failed to develop and maintain the FSEP with procedures specific to the assisted living facility and the building occupants. The FSEP had been created using a template from a third party provider evident by the following:</p> <ul style="list-style-type: none"> <li>- The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The employee actions were limited to the RACE (Remove, Alarm, Confine, Extinguish/Evacuate) acronym. The FSEP inaccurately directed the building occupants to pull the nearest fire alarm. Pull fire alarms were not installed at this facility.</li> <li>- The FSEP did not identify specific fire protection</li> </ul>	0 810		
-------	--	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>38908</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/15/2025</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>FAMILY CHOICE ASSISTED LIVING LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>272 ARLINGTON AVENUE WEST SAINT PAUL, MN 55117</b>
--	--

(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 7</p> <p>procedures for residents evident by limited instructions directing residents to stoop or crawl to avoid smoke. No additional fire protection procedures necessary for residents were included.</p> <p>- The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation during a fire or similar emergency evident by a lack of these procedures in the plan.</p> <p>During an interview on May 15, 2025, at 11:35 a.m., HM-A and CNS-B verified the FSEP required revision.</p> <p><b>TRAINING</b> Record review indicated the licensee failed to provide fire safety and evacuation training to residents at least once per year evident by the lack of documentation to support this training had been completed. No training records were provided.</p> <p>Record review indicated the licensee failed to provide training to employees on the FSEP at least twice per year evident by the lack of documentation to support this training had been completed. No training records were provided.</p> <p>During an interview on May 15, 2025, at 11:35 a.m., HM-A and CNS-B stated employees and residents were trained, but these trainings had not been documented.</p> <p><b>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</b></p>	0 810		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>38908</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/15/2025</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>FAMILY CHOICE ASSISTED LIVING LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>272 ARLINGTON AVENUE WEST SAINT PAUL, MN 55117</b>
--	--

(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 8	01060		
01060 SS=D	<p><b>144G.52 Subd. 9 Emergency relocation</b></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"> <li>(1) the reason for the relocation;</li> <li>(2) the name and contact information for the location to which the resident has been relocated and any new service provider;</li> <li>(3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities;</li> <li>(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</li> <li>(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.</li> </ul> <p>(c) The notice required under paragraph (b) must be delivered as soon as practicable to:</p> <ul style="list-style-type: none"> <li>(1) the resident, legal representative, and designated representative;</li> <li>(2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and</li> <li>(3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not</li> </ul>	01060		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>38908</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/15/2025</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>FAMILY CHOICE ASSISTED LIVING LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>272 ARLINGTON AVENUE WEST SAINT PAUL, MN 55117</b>
--	--

(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 9</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 to the resident or the resident's designated representative after an emergency relocation 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 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>R1's service plan, dated May 13, 2025, indicated R1 received services to include assistance with medication management, dressing, and grooming.</p> <p>R1's record included a hospital visit summary, dated October 3, 2024, that indicated R1 was admitted to the hospital on September 26, 2024, and was discharged back to the assisted living on October 3, 2024.</p> <p>R1's record lacked evidence a written notification was provided to R1 or their designated representative, with the following required</p>	01060		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>38908</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/15/2025</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>FAMILY CHOICE ASSISTED LIVING LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>272 ARLINGTON AVENUE WEST SAINT PAUL, MN 55117</b>
--	--

(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 10</p> <p>content:</p> <ul style="list-style-type: none"> <li>-the reason for the relocation;</li> <li>-the name and contact information for the location to which the resident has been relocated and any new service provider;</li> <li>-contact information for the Office of Ombudsman for Long-Term Care (OOLTC) and the Office of Ombudsman for Mental Health and Developmental Disabilities;</li> <li>-if known and applicable, the approximate date or range of dates within which the resident was expected to return to the facility, or a statement that a return date was not currently known; and</li> <li>-a statement that, if the facility refused to provide housing or services after a relocation, the resident had 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.</li> </ul> <p>The record further lacked evidence the required notice was also provided to the OOLTC when the resident had not returned to the facility within four days.</p> <p>On May 13, 2025, at 10:45 a.m., clinical nurse supervisor (CNS)-B stated an emergency relocation notification was not provided for R1 because she was not aware of the requirement.</p> <p>The licensee's Discharge and Transfer of Residents policy, dated September 29, 2022, indicated, "in the event of an emergency relocation, the facility will provide written notice of emergency relocation to the resident, the resident's legal representative, the resident's case manager, and if the resident has not returned to the facility within four days, the Ombudsman for Long-Term Care".</p> <p>No further information was provided.</p>	01060		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>38908</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/15/2025</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>FAMILY CHOICE ASSISTED LIVING LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>272 ARLINGTON AVENUE WEST SAINT PAUL, MN 55117</b>
--	--

(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 11	01060		
01880 SS=D	<p><b>144G.71 Subd. 19 Storage of medications</b></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: Based on observation, interview, and record review, the licensee failed to ensure medications were stored according to the manufacturer's recommendations in one of one refrigerator.</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 May 12, 2025, at 11:00 a.m., the surveyor observed the medication refrigerator located in the office of the facility. The refrigerator contained two unopened Ozempic injectable pens (medication used to improve blood sugar levels). The temperature of the refrigerator was observed to be 29 degrees Fahrenheit (F).</p>	01880		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>38908</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/15/2025</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>FAMILY CHOICE ASSISTED LIVING LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>272 ARLINGTON AVENUE WEST SAINT PAUL, MN 55117</b>
--	--

(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 12</p> <p>On May 13, 2025, at 9:00 a.m., the temperature of the medication refrigerator was observed to be 30 degrees F.</p> <p>The medication refrigerator temperature log for May 1, 2025, through May 13, 2025, documented the medication refrigerator temperatures ranged from 36-40 degrees F.</p> <p>The manufacturer's guidance for Ozempic injectable pens, dated March 2025, included to store unopened pens in the refrigerator between 36-46 degrees F.</p> <p>On May 13, 2025, at 10:20 a.m., housing manager (HM)-A stated the refrigerator temperatures were monitored daily by employees and were found to be within normal limits. HM-A was unsure why the temperatures varied. HM-A stated he would monitor the refrigerator temperatures to ensure the refrigerator was working properly.</p> <p>The licensee's Storage/Control of Medications dated September 29, 2022, indicated "medications requiring refrigeration are clearly labeled and stored in an enclosed container or area separated from foods. Temperature is maintained at 35-40 degrees."</p> <p>No further information was provided.</p> <p>TIME PERIOD TO CORRECT: Seven (7) days</p>	01880		



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

## Food & Beverage Inspection Report

Page: 1

### Establishment Info

Family Choice Assisted Living  
272 Arlington Avenue W  
St Paul, MN 55117  
Ramsey County  
Parcel:  
  
Phone:

### License Info

License: HFID 38908  
  
Risk:  
License:  
Expires on:  
CFPM: HODAN MOHAMED  
CFPM #: 32728; Exp: 03/25/2028

### Inspection Info

Report Number: F8058251019  
Inspection Type: Full - Single  
Date: 5/12/2025 Time: 3:52:49 PM  
Duration: minutes  
Announced Inspection: No  
**Total Priority 1 Orders: 1**  
Total Priority 2 Orders: 0  
Total Priority 3 Orders: 0  
Delivery: Emailed

### ! New Order: 4-700 Sanitizing Equipment and Utensils

4-703.11B *Priority Level: Priority 1 CFP#: 16*

*MN Rule 4626.0905B* Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.

COMMENT: DISH MACHINE DID NOT ACHIEVE 160 DF SANITIZER TEMP - REPAIR OR REPLACE DISH MACHINE

*Comply By: 7/31/2025 Originally Issued On: 5/12/2025*

**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 F8058251019 from 5/12/2025**

HODAN MOHAMED  
PIC

Aaron Gertz,  
Public Health Sanitarian 3  
651-201-4516  
aaron.gertz@state.mn.us