



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

June 2, 2026

Licensee

Golden Hearts Home Care Services LLC

10245 94th Avenue North

Maple Grove, MN 55369

RE: Project Number(s) SL37646016

Dear Licensee:

On June 16, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on March 26, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the March 26, 2025 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on March 26, 2025, found not corrected at the time of the June 16, 2025, follow-up survey and/or subject to penalty assessment are as follows:

0775 - Fire Protection And Physical Environment - 144g.45 Subd. 2. (a)

The details of the violations noted at the time of this follow-up survey completed on June 16, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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 outlined on the state form; however, plans of correction are not required to be submitted for approval.

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.

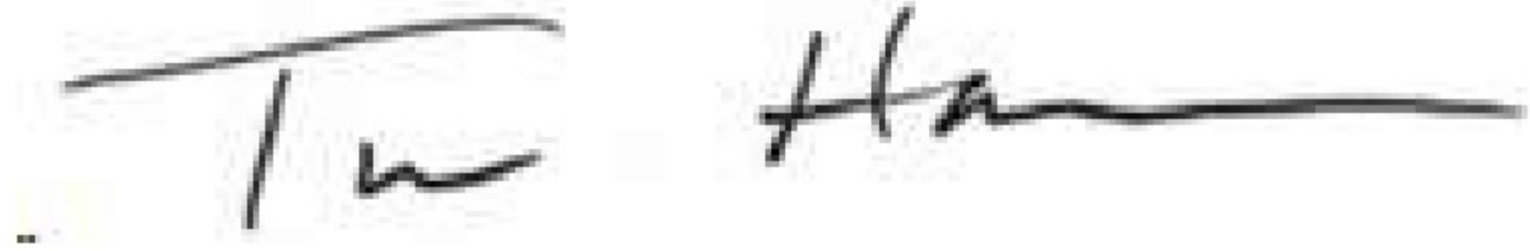
To submit a reconsideration request, please visit:

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

We urge you to review these orders carefully. If you have questions, please contact Tim Hanna at 507-208-8982.

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

Sincerely,

A handwritten signature in black ink, appearing to read "Tim Hanna", with a long horizontal flourish extending to the right.

Tim Hanna, Supervisor
State Engineering Services Section
Health Regulation Division
Email: Tim.Hanna@state.mn.us
Telephone: 507-208-8982 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37646	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 06/16/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN HEARTS HOME CARE SERVICES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 10245 94TH AVENUE NORTH MAPLE GROVE, MN 55369		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL37646016-1 On June 16, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on March 25, 2025. At the time of the survey, there were 3 residents; 3 receiving services under the Assisted Living License. As a result of the follow-up survey, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
{0 470} SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	{0 470}			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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{0 470}	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by:	{0 470}			
{0 660} SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by	{0 660}	Not reviewed during this survey		

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{0 660}	Continued From page 2 the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by:	{0 660}	Not reviewed during this survey		
{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	{0 680}			

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{0 680}	Continued From page 3 available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by:	{0 680}	Not reviewed during this survey		
{0 700} SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by:	{0 700}			
{0 775} SS=E	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee	{0 775}			

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{0 775}	Continued From page 4 failed to provide resident bedrooms with the minimum window opening meeting the minimum state standard for egress. This had the potential to affect some residents, staff, and visitors. This practice resulted in a level two violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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). The findings include: On June 16, 2025, at approximately 1:00 p.m., the surveyor spoke with the facility clinical nurse supervisor/ licensed assisted living director (CNS/LALD)-C. The CNS/LALD-C stated the deficiencies have not been addressed. The CNS/LALD-C stated the windows have been ordered and are scheduled to be installed around July 6, 2025. FINDINGS FROM INITIAL SURVEY ON MARCH 25, 2025 OCCUPIED SLEEPING ROOMS: Bedroom 4: Three transom windows measuring 43 inches clear width, 15 inches clear height, open and 645 square inches total open area for each window. UNOCCUPIED SLEEPING ROOMS: Bedroom 5: Two windows measuring 27 inches clear width, 16 1/2 inches clear height, and 445 1/2 square inches total open area.	{0 775}			

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{0 775}	Continued From page 5 Bedroom 7: Two windows measuring 35 inches clear width, 14 inches clear height, and 490 square inches total open area. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. The surveyor explained to CNS/LALD-C that at least one window in each bedroom in a state-licensed facility must meet the minimum state fire code standard for an egress window to be a complying bedroom for resident occupancy. On March 25, 2025, the surveyor explained to CNS/LALD-C that an immediate correction order was issued for the above findings. CNS/LALD-C stated they understood the requirements for egress windows and would start the process of getting the windows replaced.	{0 775}			
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced	{0 800}			

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{0 800}	Continued From page 6 by:	{0 800}	Not reviewed during this survey		
{0 810} SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	{0 810}			

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{0 810}	Continued From page 7	{0 810}	Not reviewed during this survey		
{01620} SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment.	{01620}			

Minnesota Department of Health
STATE FORM 6899 HJDK12 If continuation sheet 9 of 9



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
April 21, 2025

Licensee
Golden Hearts Home Care Services LLC
10245 94th Avenue North
Maple Grove, MN 55369

RE: Project Number(s) SL37646016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 26, 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 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.

Level 4: a fine of \$5,000 per incident, 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:

0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - \$3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:

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

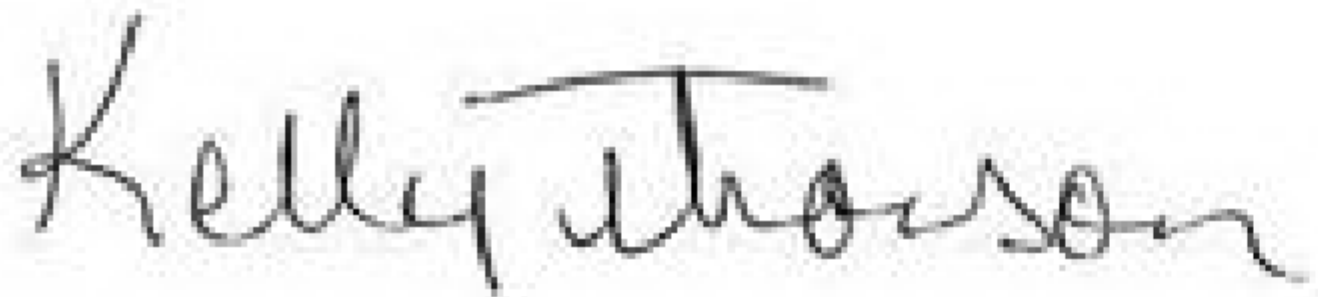
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration or a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: <https://forms.office.com/g/Bm5uQEPhVa>. Your input is important to us and will enable MDH to improve its processes and communication with providers. 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 cursive script that reads "Kelly Thorson".

Kelly Thorson, Supervisor

State Evaluation Team

Email: kelly.thorson@state.mn.us

Telephone: 320-223-7336 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

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0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL37646016-0 On March 24, 2025, through March 26, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were three resident(s); all of whom were receiving services under the Assisted Living Facility license. An immediate correction order was identified on March 25, 2025, issued for SL37646016-0, tag identification 0775. During the course of the survey, the licensee took action to mitigate the imminent risk for tag identification 0775. Noncompliance remained and the scope and level remain unchanged.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a written staffing plan that included an evaluation completed by a registered nurse at least twice a year. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37646	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/26/2025
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0 470	Continued From page 2 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On Monday March 24, 2025 at 6:56 p.m., administrator (A)-F sent an email containing the licensee's undated staffing plan. On March 26, 2025, at 9:10 a.m., licensed assisted living director (LALD)-C stated, "As I said before we review the staffing plan as we should but when we moved offices, because we had an office out of a different location, when we moved to this office I cant find it right now, but we do review it." The licensee's Staffing Policy dated August 1, 2021, indicated, "The staffing plan shall be evaluated as part of the Quality Management program at least twice per year. The results of the evaluation are documented in the meeting minutes." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470			
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current	0 660			

Minnesota Department of Health

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0 660	Continued From page 3 tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). The licensee failed to ensure screening for active TB (either a two-step tuberculin skin test (TST) or blood test) were completed and documented for one of two employees, (unlicensed personnel (ULP-B)). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-B was hired into the ULP role on July 30,	0 660			

Minnesota Department of Health

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0 660	Continued From page 4 2024, to perform direct care services to the licensee's residents. ULP-B's employee records lacked evidence of screening for active TB with either a two-step TST or blood test. On March 25, 2025, at 9:30 a.m., surveyor observed ULP-B completing the licensee's morning cleaning tasks for the facility. On March 25, 2025 at 11:45 a.m., licensed assisted living director (LALD)-C stated, "The person who worked here before [in the administrator role] she called [ULP-B's] clinic and verbally confirmed that she had a reaction, but she never got the paperwork. I am trying to see if we can get that, but the clinic said it may take some time." The licensee's Tuberculosis Screening/Prevention policy, dated, August 1, 2021, indicated TB testing with an interferon-gamma release assay (IGRA) or a tuberculin skin test (TST) would be completed for persons without documented prior TB disease or latent TB infection. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 660			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that	0 680			

Minnesota Department of Health

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0 680	Continued From page 5 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. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to have a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all residents receiving services under the assisted living license. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect	0 680			

Minnesota Department of Health

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0 680	Continued From page 6 a large portion or all of the residents). The findings include: The licensee's undated EP plan lacked evidence of the following required content: - develop and maintain an EP plan and be updated annually, must document date of review and any updates made to the plan based on the review; - subsistence needs for staff and residents including food, water, medical supplies, pharmaceutical supplies, alternate sources of energy to maintain temperatures to protect resident health/safety, safe/sanitary storage of provisions, emergency lighting, fire detection, extinguishing, alarm systems, sewage and waste disposal; - policies and procedures for volunteers; - policy or procedure to address role of facility under a waiver declared by the Secretary in accordance with section 1135 of the Act; - participate in an annual full-scale exercise that is community based OR conduct an annual, individual, facility-based functional exercise OR if the facility experiences an actual emergency requiring activation of plan, facility is exempt from engaging in its next required full-scale exercise; - conduct an additional annual exercise that may include: a second full-scale exercise that is community-based or an individual, facility based functional exercise OR mock disaster drill OR table-top exercise; and -analyze the facility's response to and maintain documentation of all drills, tabletop exercises and emergency events & revise plan as needed. On March 25, 2025, at 10:33 a.m., licensed assisted living director (LALD)-C stated, "I don't think I will be able to find that information. We do	0 680			

Minnesota Department of Health

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0 680	Continued From page 7 a missing person drill and fire drills that's it." When asked if there was documentation of the missing person drills, LALD-C stated, "It is just something we talked about." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one resident's (R2) personal health and medical information was kept private. 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).	0 700			

Minnesota Department of Health

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0 700	Continued From page 8 The findings include: On March 24, 2025, at 11:47 a.m., unlicensed personnel (ULP)-E was observed sitting at the computer charting. With Rtasks (a computer charting software) opened ULP-E left the computer and went outside, and then came back inside and went to other parts of the facility to take care of other tasks. ULP-E returned to the computer to finish charting at 11:50 a.m. There was one other resident in the common area while Rtasks was left open. On March 24, 2025, at 11:47 a.m., ULP-E stated, "I must have forgot to shut this." On March 26, 2025, at 9:10 a.m., licensed assisted living director (LALD)-C stated, "The only resident information the staff has is on the computer, we told them anytime they move away from the computer they put it to sleep otherwise if the computer doesn't get used for a few minutes it puts itself to sleep." The licensee's Privacy of Protected Health Information policy, dated August 1, 2021, indicated, "Staff will maintain confidentiality of protected health information in the office and when doing business on behalf of [Licensee]. No clinical records or personal health information about residents will be accessible in public areas of the office. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700			

Minnesota Department of Health

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0 775	Continued From page 9	0 775			
0 775 SS=H	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedrooms with the minimum window opening meeting the minimum state standard for egress. This had the potential to affect some residents, staff, and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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). The findings include: On March 25, 2025, at approximately 11:30 a.m., the surveyor toured the facility with licensed assisted living director/clinical nurse supervisor (CNS/LALD)-C. During the tour, the surveyor asked CNS/LALD-C to open the windows in the resident bedrooms for measurement. The noncompliant measurements were as follows: OCCUPIED SLEEPING ROOMS: Bedroom 4: Three transom windows measuring 43 inches clear width, 15 inches clear height,	0 775	During the course of the survey, the licensee took action to mitigate the imminent risk. Noncompliance remained and the scope and level remain unchanged.		

Minnesota Department of Health

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0 775	Continued From page 10 open and 645 square inches total open area for each window. UNOCCUPIED SLEEPING ROOMS: Bedroom 5: Two windows measuring 27 inches clear width, 16 1/2 inches clear height, and 445 1/2 square inches total open area. Bedroom 7: Two windows measuring 35 inches clear width, 14 inches clear height, and 490 square inches total open area. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. The surveyor explained to CNS/LALD-C that at least one window in each bedroom in a state-licensed facility must meet the minimum state fire code standard for an egress window to be a complying bedroom for resident occupancy. On March 25, 2025, the surveyor explained to CNS/LALD-C that an immediate correction order was issued for the above findings. CNS/LALD-C stated they understood the requirements for egress windows and would start the process of getting the windows replaced. TIME PERIOD FOR CORRECTION: Immediate.	0 775			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of	0 800			

Minnesota Department of Health

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0 800	Continued From page 11 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 with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On March 25, 2025, at approximately 11:00 a.m., the surveyor toured the facility with clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C. The following was observed. GENERAL MAINTENANCE: The lower-level kitchen area appeared to have a sink removed. The plumbing drain was exposed and not capped. The surveyor explained to CNS/LALD-C that the sewer pipe needed to be capped to prevent sewer gas from entering the	0 800			

Minnesota Department of Health

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0 800	Continued From page 12 facility. On March 25, 2025, CNS/LALD-C stated they understood the issue and would get the sewer pipe capped. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill	0 810			

Minnesota Department of Health

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0 810	Continued From page 13 every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On March 25, 2025, at approximately 11:00 a.m., the surveyor observed the fire evacuation diagrams indicating the garage is used as a dedicated exit. Exits shall lead directly to the exterior of the building and not pass through the garage. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP failed to include the following: The FSEP included standard employee	0 810			

Minnesota Department of Health

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0 810	Continued From page 14 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. During the tour CNS/LALD-C indicated the staff uses the ramp in the garage as an exit during an emergency. The procedures for using the ramp and how to exit the space during an emergency where not outlined in the FSEP. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. On March 25, 2025, CNS/LALD-C acknowledged the areas of their policy that were incomplete and would work on bringing them into compliance. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. CNS/LALD-C lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. On March 25, 2025, CNS/LALD-C acknowledged they understood the requirements for training residents and would implement a training program that was compliant with statute requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37646	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/26/2025
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01620	Continued From page 15 (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) 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. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted the initial RN assessment prior to contract signing or move in date, and ongoing nursing assessments not to exceed every 90-days for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37646	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/26/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN HEARTS HOME CARE SERVICES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 10245 94TH AVENUE NORTH MAPLE GROVE, MN 55369		
(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 16 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted to the licensee and began receiving services on August 24, R1's record included an admission assessment dated, August 27, 2024. R1's record lacked an initial assessment prior to contract signing or move in date. R1's record also included 90-day assessments dated October 9, 2024, and January 19, 2025 indicating 102 days had passed between assessments. On March 25, 2025, at 12:17 p.m., licensed assisted living director, (LALD)-C stated, "You know sometimes I do it, but I don't always submit it and sign it that same day, so that date was the day it was submitted." The licensee's Assessment and Reassessment policy dated August 1, 2021, indicated, "The initial RN assessment shall be completed prior to the date on which the prospective resident executes a contract or on the date on which the prospective resident moves in, whichever is earlier." The policy also indicated, "Ongoing resident reassessments must be conducted by an RN and cannot exceed 90 days from the last date of assessment." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37646	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/26/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN HEARTS HOME CARE SERVICES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 10245 94TH AVENUE NORTH MAPLE GROVE, MN 55369		
(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
02290	Continued From page 17	02290			
02290 SS=F	144G.91 Subd. 2 Legislative intent The rights established under this section for the benefit of residents do not limit any other rights available under law. No facility may request or require that any resident waive any of these rights at any time for any reason, including as a condition of admission to the facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee established written house rules and regulations that used language which limited the rights for one of one resident (R1). This had the potential to affect all residents residing within the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On March 24, 2025, at 11:00 a.m., licensed assisted living director (LALD)-C provided surveyor with R1's files that included a form titled "Resident Guidelines" signed and dated August 24, 2023, and indicated, "All residents are required to attend all psychiatrist and medical, and social service appointments. There are no street drugs, alcohol, or over the counter medications allowed on the property or in your room. Any violation of this rule will result in	02290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37646	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/26/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN HEARTS HOME CARE SERVICES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 10245 94TH AVENUE NORTH MAPLE GROVE, MN 55369		
(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
02290	Continued From page 18 termination of your housing and services contract and notification of the appropriate law enforcement agencies. Curfew is 10 p.m. Sunday-Thursday. Curfew is 11 p.m. Friday and Saturday. Residents are required to call when late to let staff know they are coming home. Visitors must check in with staff. No visitors after 9 p.m. Visitors must provide a picture ID before being admitted to [Licensee]. They must also be on the residents approved visitor list before gaining access to the building. No stealing. Residents must always be properly clothed. You must have a top, bottom, and something covering feet always." The form also indicated, "I agree to follow all the rules, I understand that if I choose to break the rules then I can be evicted from [Licensee]. On March 24, 2025, at 12:03 LALD-C acknowledged that all residents are given the Resident Guidelines form to sign and follow. On March 25, 2025, at 1:30 LALD-C stated, "Well in this home nobody drinks, so I guess instead we should just use a softer language for our house rules." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02290			



Minnesota Department of Health

625 North Robert Street
Saint Paul, MN
651-201-5000

Type: Full
Date: 03/25/25
Time: 13:00:00
Report: 8087251070

Food and Beverage Establishment Inspection Report

Page 1

Location:

Golden Hearts Home Care Service
10245 94th Avenue North
Maple Grove, MN 55369
Hennepin County, 27

Establishment Info:

ID #: 0038455
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7635283891
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

No NEW orders were issued during this inspection.

Food and Equipment Temperatures

Process/Item: Ambient Air

Temperature: 38 Degrees Fahrenheit - Location: REFRIGERATOR

Violation Issued: No

Process/Item: Cold Holding: MILK

Temperature: 37 Degrees Fahrenheit - Location: REFRIGERATOR

Violation Issued: No

Process/Item: Cold Holding: CHEESE

Temperature: 38 Degrees Fahrenheit - Location: REFRIGERATOR

Violation Issued: No

Process/Item: Cold Holding: YOGURT

Temperature: 38 Degrees Fahrenheit - Location: REFRIGERATOR

Violation Issued: No

Process/Item: Ambient Air

Temperature: 3 Degrees Fahrenheit - Location: FREEZER

Violation Issued: No

Total Orders	In This Report	Priority 1	Priority 2	Priority 3
		0	0	0

THIS WAS AN ANNOUNCED AND SCHEDULED FULL INSPECTION.

INSPECTION CONDUCTED IN THE PRESENCE OF NURSE EVALUATOR TESA BROWN.

FLOORS ARE LAMINATE, CABINETS ARE HARDWOOD AND CEILING IS TEXTURED AND DOES NOT APPEAR TO BE DURABLE, SMOOTH IN TEXTURE OR EASILY CLEANABLE. ALL ARE

Type: Full
Date: 03/25/25
Time: 13:00:00
Report: 8087251070
Golden Hearts Home Care Servic

Food and Beverage Establishment Inspection Report

Page 2

FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

BOSCH BRAND DISHWASHER IS RESIDENTIAL BUT HAS SANITIZING RINSE CYCLE OPTION.

HOT WATER TEMPERATURE AT THE KITCHEN SINK REACHED 120 DEGREES.

DESIGNATED HAND WASHING SINK IN THE KITCHEN IS THE LEFT SIDE OF A 2-BIN, STAINLESS STEEL RESIDENTIAL KITCHEN SINK.

INSPECTION REPORT EMAILED TO TESA BROWN.

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 8087251070 of 03/25/25.

Certified Food Protection Manager: JOSEPHINE M. BALL

Certification Number: FM110616 Expires: 03/31/25

Inspection report reviewed with person in charge and emailed.

Signed: _____

JOSEPHINE M. BALL
HOUSE MANAGER

Signed: _____

John Boettcher
Public Health Sanitarian 3
St. Paul, MN / Freeman
651-201-5076
john.boettcher@state.mn.us