Electronically Delivered

July 27, 2023

Licensee
Care Homes LLC
4045 Xenia Avenue North
Robbinsdale, MN 55422

RE: Project Number(s) SL38205015

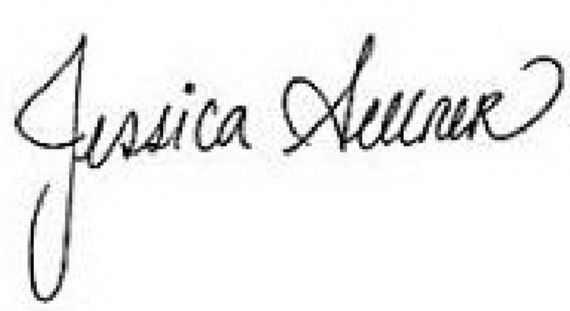
Dear Licensee:

On July 24, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the May 24, 2023, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,



Jessica Sellner, Supervisor
State Rapid Response Team
Email: jessica.sellner@state.mn.us
Telephone: 320-223-7370 Fax: 651-281-9796

JMD

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

June 23, 2023

Licensee
Care Homes LLC
4045 Xenia Avenue North
Robbinsdale, MN 55422

RE: Project Number(s) SL38205015

Dear Licensee:

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

The Minnesota Department of Health completed an initial survey on May 24, 2023, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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

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

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

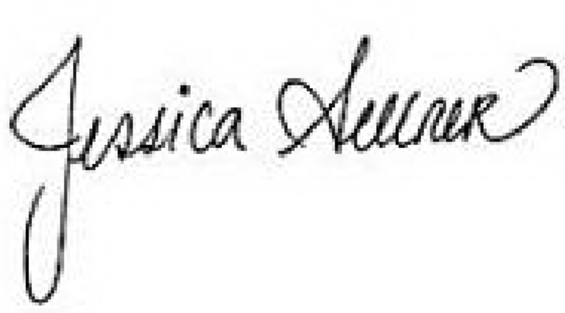
Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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.

If you have any questions, please contact me.

Sincerely,



Jessica Sellner, Supervisor
State Rapid Response Team
Email: jessica.sellner@state.mn.us
Telephone: 320-223-7370 Fax: 651-215-6894

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38205	A. BUILDING: _____ B. WING _____	05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE HOMES LLC	4045 XENIA AVENUE NORTH ROBBINSDALE, MN 55422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDERS In accordance with Minnesota Statutes, section 144A.43 to 144A.482/144G.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: #SL38205015 On May 22-24, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey and investigation, there were 3 residents receiving services under the provider's Provisional Assisted Living Facility license.	0 000		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for 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	0 470		

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0 470	Continued From page 1 (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 a staffing plan to determine appropriate staffing levels for the facility as required. This had the potential to affect all residents receiving services from the licensee. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee failed to develop and implement a	0 470		

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0 470	Continued From page 2 staffing plan to determine appropriate staffing levels that: - included an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility. - ensured 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 - ensured 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. On May 24, 2023, at 11:45 a.m., licensed assisted living director (LALD)-A stated the facility was staffed according to need and resident census. LALD-A stated the facility did not have a written staffing plan in place to address staffing levels. The licensee's policy titled Staffing & Scheduling, dated August 1, 2021, indicated the clinical nurse supervisor would develop and implement a written staffing plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules,	0 480		

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0 480	Continued From page 3 chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to comply with Minnesota Food Code, Chapter 4626. This had the potential to affect all three (3) residents residing at 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, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the additional documentation included in the Food and Beverage Establishment Inspection Reports dated May 22, 2023. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 480		
0 490 SS=C	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance;	0 490		

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0 490	Continued From page 4 (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide daily programs of social and recreational activities based on individual and group interests. This had the potential to affect all three (3) residents of the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On May 22, 2023, the surveyor observed no activities were planned or offered to the residents. A calendar of activities was requested but not provided. On May 24, 2023, at 11:45 a.m., licensed	0 490		

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0 490	Continued From page 5 assisted living director (LALD)-A stated staff take residents out, however, the facility did not have a daily activity program developed. The licensee's policy titled Activity Programming, dated August 1, 2021, indicated a monthly activity calendar would be created and made available to all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 490		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in quality management activity appropriate to the size of the facility and relevant to the type of services provided and failed to maintain documentation on quality management activities. This had the potential to	0 580		

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0 580	Continued From page 6 affect all three (3) residents receiving services from the licensee. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference interview on May 22, 2023, at 10:00 a.m., licensed assisted living director (LALD)-A and registered nurse (RN)-B verbalized familiarity with quality management requirements in the assisted living statutes. On May 22, 2023, at 10:00 a.m., the surveyor requested documented evidence of quality management activities for the facility. LALD-A stated staff incorporate quality management into scheduled staff meetings and discuss concerns then. The licensee's undated policy titled Quality Management Project, dated August 1, 2021, indicated the licensee would have a documented quality management project in place at all times. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		

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0 650	Continued From page 7	0 650		
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure employee records contained the required orientation and competency training content and documentation for six of six staff members, registered nurse (RN)-B, RN-C, unlicensed personnel (ULP)-D, ULP-E, ULP-F, and ULP-G, with employee records reviewed. This had the potential to affect all residents in the facility. This practice resulted in a level two violation (a	0 650		

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0 650	Continued From page 8 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: RN-B was hired on November 22, 2022, to provide direct-care services under the facility's Assisted Living license. RN-B's employee record lacked documentation of the following required components of assisted living orientation: -Overview of Assisted Living statutes -Review of provider's policies and procedures -Handling of resident complaints -Consumer advocacy services -Review of types of assisted living services the employee will provide and provider's scope of license -Principles of person-centered planning/service delivery RN-C was hired on July 18, 2022, to provide direct-care services under the facility's Assisted Living license. RN-C's employee record lacked documentation of the following required components of assisted living orientation: -Review of provider's policies and procedures -Handling of resident complaints -Consumer advocacy services	0 650		

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0 650	Continued From page 9 -Review of types of assisted living services the employee will provide and provider's scope of license -Principles of person-centered planning/service delivery ULP-D was hired on July 18, 2022, to provide direct-care services under the facility's Assisted Living license. ULP-D's employee record lacked documentation of required competency evaluations for the following tasks: -appropriate and safe techniques in personal hygiene and grooming, including -hair care and bathing -care of teeth, gums, and oral prosthetic devices -care and use of hearing aids -dressing and assisting with toileting -standby assistance techniques and how to perform them; -safe transfer techniques and ambulation; -range of motion and positioning; -administering medications or treatments as required ULP-E was hired on July 16, 2021, to provide direct-care services under the facility's Assisted Living license. ULP-E's employee record lacked documentation of the following required components of assisted living orientation: -Overview of Assisted Living statutes -Review of provider's policies and procedures -Handling emergencies and using emergency services	0 650		

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0 650	Continued From page 10 -Reporting maltreatment of vulnerable adults or minors -Assisted Living bill of rights -Handling of resident complaints -Consumer advocacy services -Review of types of assisted living services the employee will provide and provider's scope of license -Principles of person-centered planning/service delivery In addition, ULP-E's file lacked documentation of required competency evaluations for the following tasks: -appropriate and safe techniques in personal hygiene and grooming, including -hair care and bathing -care of teeth, gums, and oral prosthetic devices -care and use of hearing aids -dressing and assisting with toileting -standby assistance techniques and how to perform them; -reading and recording temperature, pulse, and respirations of the client; -safe transfer techniques and ambulation; -range of motion and positioning; -administering medications or treatments as required. ULP-F was hired on July 6, 2022, to provide direct-care services under the facility's Assisted Living license. ULP-F's file lacked documentation of required competency evaluations for the following tasks: -appropriate and safe techniques in personal hygiene and grooming, including	0 650		

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0 650	Continued From page 11 -hair care and bathing -care of teeth, gums, and oral prosthetic devices -care and use of hearing aids -dressing and assisting with toileting -standby assistance techniques and how to perform them; -reading and recording temperature, pulse, and respirations of the client; -safe transfer techniques and ambulation; -range of motion and positioning; -administering medications or treatments as required. ULP-G was hired on December 27, 2022, to provide direct-care services under the facility's Assisted Living license. ULP-G's file lacked documentation of required competency evaluations for the following tasks: -appropriate and safe techniques in personal hygiene and grooming, including -hair care and bathing -care of teeth, gums, and oral prosthetic devices -care and use of hearing aids -dressing and assisting with toileting -standby assistance techniques and how to perform them; -reading and recording temperature, pulse, and respirations of the client; -safe transfer techniques and ambulation; -range of motion and positioning; -administering medications or treatments as required. On May 24, 2023, at 11:45 a.m., LALD-A stated staff training was completed, but employee files might not contain all training documentation.	0 650		

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0 650	Continued From page 12 The licensee's policy titled Competency Training Evaluations, dated August 1, 2021, indicated a copy of all education, training, and competency testing will be kept in each employee's personnel file. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to 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	0 660		

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	38205	A. BUILDING: _____ B. WING _____	05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE HOMES LLC	4045 XENIA AVENUE NORTH ROBBINSDALE, MN 55422

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0 660	Continued From page 13 licensee failed to complete a facility tuberculosis (TB) risk assessment, nor was there evidence of TB training for six of six (6) employees (Registered Nurse/RN)-B, RN-C, Unlicensed Personnel/(ULP)-D, ULP-E, ULP-F, and ULP-G), with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: RN-B was hired on November 22, 2022, to provide direct care and supervision of care to residents and supervision of unlicensed personnel. RN-C was hired on March 8, 2022, to provide direct care and supervision of care to residents and supervision of unlicensed personnel. ULP-D was hired on July 18, 2022, to provide direct care services to residents under the licensee's assisted living license. ULP-E was hired on July 16, 2021, to provide direct care services to residents under the licensee's assisted living license. ULP-F was hired on July 6, 2022, to provide direct care services to residents under the licensee's assisted living license.	0 660		

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0 660	Continued From page 14 ULP-G was hired on December 27, 2022, to provide direct care services to residents under the licensee's assisted living license. All the above personnel files lacked evidence of TB training at the time of hire. A review of documents provided by the licensee revealed that no TB risk assessment was completed for the facility. During an interview on May 22, 2023, at 10:00 a.m., licensed assisted living director (LALD)-A, stated he had started a facility TB risk assessment but had not finished it. LALD-A, RN-B, and RN-C stated they were familiar with requirements for TB training and developing a facility TB risk assessment. The licensee's policy titled Tuberculosis Screening dated August 1, 2021, indicated the licensee would maintain a current community TB risk assessment and that staff would be educated regarding TB at the time of hire. 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 contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff	0 680		

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	38205	A. BUILDING: _____ B. WING _____	05/24/2023

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0 680	Continued From page 15 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 observation, interview, and record review the licensee failed to develop a written emergency disaster preparedness plan (EPP) with all the required content and failed to post an emergency preparedness plan prominently. 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 the potential to affect a large portion or all of the residents).	0 680		

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	38205	A. BUILDING: _____ B. WING _____	05/24/2023

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0 680	Continued From page 16 The findings include: During entrance conference on May 22, 2023, at 9:45 a.m., a request was made to view the licensee's emergency disaster preparedness plan. During a facility tour at 10:30 a.m. there was no observed signage posted or information regarding the licensee's emergency plan in shared areas. The licensee's undated emergency plan lacked evidence of the following required content: - development of policies/procedures to address: -a tracking system used to document locations of volunteers in the facility -a system of medical documentation that preserve resident information, protects confidentiality, and secures/maintains availability of records - primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management agencies -a communication plan that included the names and contact information of current staff, entities providing services under the emergency agreement, residents' physicians, other facilities, and volunteers -a communication plan that included a method for sharing information from the emergency plan with residents and/or their families/representatives -documentation of exercises to test the EPP at least twice a year, including unannounced staff drills using the EPP	0 680		

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	38205	A. BUILDING: _____ B. WING _____	05/24/2023

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0 680	Continued From page 17 The licensee's emergency plan was undated and thus unable to be determined if any updates had occurred in accordance with 144G statutes. However, a communication plan included the name and contact information for a nurse that no longer worked at the facility. On May 24, 2023, at 11:45 a.m., licensed assisted living director (LALD)-A stated he was unaware of the deficiencies of the EPP and would work to correct them. The licensee's undated Disaster Planning and Emergency Preparedness policy indicated the licensee would have in place an emergency preparedness plan that would comply with Centers for Medicare & Medicaid Services (CMS) Appendix Z. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story	0 780		

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	38205	A. BUILDING: _____ B. WING _____	05/24/2023

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0 780	Continued From page 18 within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that are interconnected so that actuation of one alarm causes all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. 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 facility the tour with the Assisted Living Director (LALD)-A on May 24, 2023, at approximately 10:00 a.m., it was observed that upon testing, the smoke alarms in the facility were not interconnected so that the actuation of	0 780		

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	38205	A. BUILDING: _____ B. WING _____	05/24/2023

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0 780	Continued From page 19 one smoke alarm would cause all other alarms in the facility to actuate. These deficient conditions were visually verified by LALD-A accompanying the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
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) employee 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) Employees 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 employees	0 810		

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0 810	Continued From page 20 twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop a fire safety and evacuation plan with required elements; licensee failed to provide a maintained fire safety and evacuation plan that contains employee actions to be taken in the event of a fire or similar emergency, fire protection procedures necessary for residents, and procedures necessary for resident movement, evacuation, or relocation during fire or similar emergency with identification of unique or unusual resident needs for the movement or evacuation. This 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: An interview and record review of the available documentation were conducted on May 24, 2023, at approximately 10:00 a.m., with the Licensed Assisted Living Director (LALD)-A on the fire safety and evacuation plan, fire safety and	0 810		

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0 810	Continued From page 21 evacuation training for the facility, and fire safety and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan. During the interview, LALD-A verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of the available documentation indicated that the fire safety and evacuation plan did not include the identification of unique or unusual resident needs for movement or evacuation in the procedures for resident movement, evacuation, or relocation during a fire or similar emergency. During the interview, LALD-A stated he was not aware of any provisions in the fire safety and evacuation plan for this requirement. During the facility tour, it was observed that the fire safety and evacuation plans were not posted on the lower levels on both address 4047 side and address 4045 side. During the facility tour, it was also observed that the two sides of the building were connected by a door on the lower level. But the posted fire safety and evacuation plan showed only a partial facility layout and did not show accurate depictions of the egress route to match the installed overhead exit signage location. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		

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	38205	A. BUILDING: _____ B. WING _____	05/24/2023

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0 820	Continued From page 22	0 820		
0 820 SS=E	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect all residents and staff. 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 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). On May 24, 2023, at approximately 10:00 a.m., survey staff toured the facility with the Assisted Living Director (LALD)-A. During the facility tour, survey staff observed the following items:	0 820		

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	38205	A. BUILDING: _____ B. WING _____	05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 820	Continued From page 23 It was observed that bedroom #2 on the main level in the address 4047 sides did not have windows that met the minimum size requirements for egress escape. The sleeping room was not occupied by residents. The clear openable area of the opened windows measured 17 inches in width and 31 inches in height and did not meet the minimum required opening for existing sleeping rooms of 648 square inches. It was observed that bedroom #2 on the main level in the address 4045 sides did not have windows that met the minimum size requirements for egress escape. The sleeping room was not occupied by residents. The clear openable area of the opened windows measured 17 inches in width and 34 inches in height and did not meet the minimum required opening for existing sleeping rooms of 648 square inches. This deficient condition was verified by LALD-A accompanying on the facility tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 820		
01360 SS=F	144G.61 Subdivision 1 Instructor and competency evaluation requirem Instructors and competency evaluators must meet the following requirements: (1) training and competency evaluations of unlicensed personnel who only provide assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), must be conducted by individuals with work experience and training in providing these services; and (2) training and competency evaluations of unlicensed personnel providing assisted living	01360		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38205	A. BUILDING: _____ B. WING _____	05/24/2023

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01360	Continued From page 24 services must be conducted by a registered nurse, or another instructor may provide training in conjunction with the registered nurse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure competency evaluations were conducted by a registered nurse (RN) for three of four unlicensed personnel (ULP)-D, ULP-E, and ULP-F with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-D was hired on July 18, 2022, to provide direct care services to residents under the licensee's assisted living license. Review of ULP-D's training record indicated ULP-D was competency-trained by a licensed practical nurse (LPN) in the following areas: -measuring vital signs (temperature, blood pressure, oxygen saturation, weights, respirations; -oral medications ULP-D's vital signs training record was signed by an LPN on July 20, 2022. ULP-D's oral medications record was signed by an LPN on July	01360		

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	38205	A. BUILDING: _____ B. WING _____	05/24/2023

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01360	Continued From page 25 19, 2022. Neither document indicated the training was conducted in conjunction with a RN. ULP-E was hired on July 16, 2021, to provide direct care services to residents under the licensee's assisted living license. Review of ULP-E's training record indicated ULP-E was competency-trained by an LPN in the following areas: -medication, exercise, and treatment reminders; -blood glucose testing. ULP-E's medication, exercise and treatment reminders training record was signed by an LPN on August 21, 2021. ULP-E's blood glucose testing training record was signed by an LPN on August 9, 2021. Neither document indicated the training was conducted in conjunction with a RN. ULP-F was hired on July 6, 2022, to provide direct care services to residents under the licensee's assisted living license. Review of ULP-F's training record indicated ULP-F was competency-trained by an LPN in the following areas: -blood glucose testing; -measuring vital signs (temperature, blood pressure, oxygen saturation, weights, respirations; ULP-F's blood glucose testing training record was signed by an LPN on July 8, 2022. ULP-F's vital signs training record was signed by an LPN on July 8, 2022. Neither document indicated the training was conducted in conjunction with a RN.	01360		

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	38205	A. BUILDING: _____ B. WING _____	05/24/2023

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01360	Continued From page 26 On May 24, 2023, at 11:45 a.m., licensed assisted living director (LALD)-A stated he was aware of the requirement for RNs to provide staff training. The licensee's policy titled Competency Training Evaluations, dated August 1, 2021, indicated training and competency evaluations would be conducted by a RN, or another instructor in conjunction with a RN. TIME PERIOD TO CORRECT: Twenty-one (21) days.	01360		
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38205	A. BUILDING: _____ B. WING _____	05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE HOMES LLC	4045 XENIA AVENUE NORTH ROBBINSDALE, MN 55422

(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
01530	Continued From page 27 until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure six of six employees, registered nurse (RN)-B, RN-C, unlicensed personnel (ULP)-D, ULP-E, ULP-F, and ULP-G, received the required amount of dementia care training in the required orientation time frame. This had the potential to affect all residents. 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 the residents). The finding include: RN-B was hired on November 22, 2022, to provide direct care and supervision of care to residents and supervision of unlicensed personnel. RN-C was hired on March 8, 2022, to provide direct care and supervision of care to residents and supervision of unlicensed personnel. Employee files for the above-noted RNs lacked documentation of eight hours of initial dementia care training within 120 hours of hire. ULP-D was hired on July 18, 2022, to provide	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38205	A. BUILDING: _____ B. WING _____	05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01530	Continued From page 28 direct care services to residents under the licensee's assisted living license. ULP-E was hired on July 16, 2021, to provide direct care services to residents under the licensee's assisted living license. ULP-F was hired on July 6, 2022, to provide direct care services to residents under the licensee's assisted living license. ULP-G was hired on December 27, 2022, to provide direct care services to residents under the licensee's assisted living license. Employee files for the above-noted ULPs lacked documentation of eight hours of initial dementia care training within 160 hours of hire. On May 24, 2023, at 11:45 a.m., licensed assisted living director (LALD)-A stated he was aware of the requirements for dementia care training. The licensee's policy titled Dementia Training, dated August 1, 2021, indicated supervisors of direct care staff would complete eight hours of initial training within 120 hours of hire. The policy also indicated direct care staff would complete eight hours of training within 160 hours of hire. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	01530		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38205	A. BUILDING: _____ B. WING _____	05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
03090	Continued From page 29 entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure a required notice was posted at the main entryway of the facility to display statutory language disclosing electronic monitoring activity. This had the potential to affect all residents, staff, and visitors to the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On May 22, 2023, at 9:45 a.m., observation was made of the main entrance at the facility. There was no signage notifying visitors of the licensee's electronic monitoring. On May 22, 2023, at 10:30 a.m., during a tour of the facility, no electronic monitoring signage was observed anywhere in the facility, nor at the other entrances and exits. On May 24, 2023, at 11:45 a.m., licensed assisted living director (LALD)-A stated he was aware of the statutory requirement for posting an electronic monitoring notice and would post	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38205	A. BUILDING: _____ B. WING _____	05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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03090	Continued From page 30 notices at all entrances of the facility. The licensee's policy titled Electronic Monitoring, dated August 1, 2021, indicated signs regarding electronic monitoring would be posted at each facility entrance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090		

DEPARTMENT OF HEALTH

Type: Full
Date: *05/22/23*
Time: 12:00:56
Report: 1036231129

Food and Beverage Establishment Inspection Report

Location:
Care Homes LLC
4045 Xenia Avenue N
Robbinsdale, MN55422
Hennepin County, 27

Establishment Info:
ID #: 0041259
Risk:
Announced Inspection: Yes

License Categories:

Expires on: 12/31/23

Operator:

Phone #:
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.

The following orders were issued during this inspection.

3-500C Microbial Control: date marking

3-501.17B ***** Priority 2 *****

MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.

NO DATE LABELS ON BAG OF CHEESE AND YOGURT IN FRIDGE. ISSUE CORRECTED ON SITE.

Comply By: 05/22/23

4-300 Equipment Numbers and Capacities

4-302.13B ***** Priority 2 *****

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

NO DEVICE ON HAND FOR MEASURING HOT WATER DISH MACHINE TEMPERATURE. OBTAIN AND MAINTAIN SUCH A DEVICE.

Comply By: 06/22/23

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

NO CURRENT CFPM AT ESTABLISHMENT. INFORMATION FOR OBTAINING A CFPM CERTIFICATE PROVIDED DURING INSPECTION.

Type: Full
Date: *05/22/23*
Time: 12:00:56
Report: 1036231129
Care Homes LLC

Food and Beverage Establishment Inspection Report

Comply By: 08/22/23

Surface and Equipment Sanitizers

UTENSIL SURFACE TEMP: = at >160 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/YOGURT
Temperature: 37 Degrees Fahrenheit - Location: KITCHEN FRIDGE
Violation Issued: No

Process/Item: Ambient Temp
Temperature: 36 Degrees Fahrenheit - Location: KITCHEN FRIDGE
Violation Issued: No

Process/Item: Ambient Temp
Temperature: 1 Degrees Fahrenheit - Location: KITCHEN FREEZER
Violation Issued: No

Process/Item: Ambient Temp
Temperature: 2 Degrees Fahrenheit - Location: CHEST FREEZER
Violation Issued: No

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

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. SURVEYOR FROM HRD WAS MAERIN RENEE. INSPECTION CONDUCTED WITH KITCHEN MANAGER KOU DUANAH.

DISCUSSED ALL ORDERS ON SITE IN ADDITION TO THE FOLLOWING:
- EMPLOYEE ILLNESS LOG AND EXCLUSION POLICY.
- SANITIZER USE AND TEST KITS.
- HAND WASHING POLICY AND REVIEW.
- NO BARE HAND CONTACT WITH RTE FOOD.
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS
- THERMOMETER USE AND CALIBRATION.
- DATE MARKING.
- PEST CONTROL.

FOR CORRECT BY DATES REFER TO COMPLETE REPORT ISSUED BY HRD.

THIS FACILITY DOES NOT HAVE COMMERCIAL GRADE ANSI EQUIPMENT. ALL FOOD MUST BE SERVED THE SAME DAY IT IS PREPARED, AND LEFTOVERS CAN NEVER BE SAVED.

REVIEWED THE SYMPTOMS OF FOODBORNE ILLNESSES AND THE REQUIREMENT TO MAINTAIN A DOCUMENTED RECORD OF ALL INSTANCES OF EMPLOYEES BEING ILL WITH EITHER VOMITING OR DIARRHEA AS REQUIRED BY THE MINNESOTA FOOD CODE & EXCLUDE

Type: Full
Date: *05/22/23*
Time: 12:00:56
Report: 1036231129
Care Homes LLC

Food and Beverage Establishment Inspection Report

ILL WORKERS FROM WORKING WITH FOOD & BEVERAGES UNTIL 24 HOURS AFTER SYMPTOMS HAVE ENDED.

**IF ANY RESIDENTS OR STAFF COMPLAIN OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE CUSTOMER. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.

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

I acknowledge receipt of the inspection report number 1036231129 of 05/22/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
KOU DUANAH
KITCHEN MANAGER

Signed:_____
Jeff Johanson