Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

March 17, 2025

Licensee
United Social Service Of Mn
1020 East 25th Street
Minneapolis, MN 55404

RE: Project Number(s) SL37495015

Dear Licensee:

On November 27, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the September 18, 2024, survey were corrected. This follow-up survey verified that the facility is back in 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,

Benjamin J. Zwart, P.E., Supervisor
State Engineering Services Section
Health Regulation Division
Email: Benjamin.Zwart@state.mn.us
Telephone: 651-201-3715 Fax: 1-866-890-9290

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Electronically Delivered

October 21, 2024

Licensee
United Social Service of MN LLC
1020 East 25th Street
Minneapolis, MN 55404

RE: Project Number(s) SL37495015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 18, 2024, 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 . . ."

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

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

The correction order documentation should include the following:

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

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

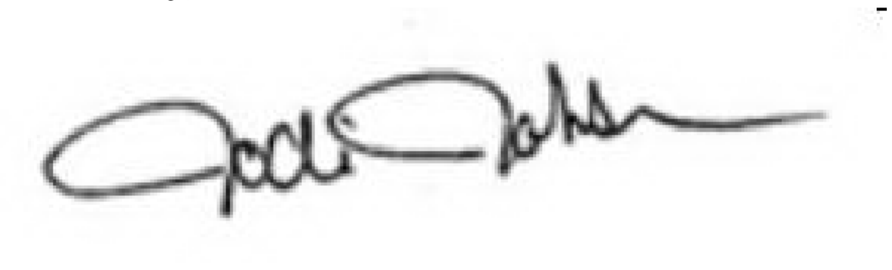
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us 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,



Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37495	A. BUILDING: _____ B. WING _____	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED SOCIAL SERVICE OF MN	1020 EAST 25TH STREET MINNEAPOLIS, MN 55404

(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 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: SL37495015 On September 16, 2024, through September 18, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were two residents; two receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (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, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated September 16, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements:	0 680		

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0 680	Continued From page 2 (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. 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, staff, and visitors of 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 potential to affect	0 680		

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0 680	Continued From page 3 a large portion or all of the residents). The findings include: -The licensee's Emergency Preparedness manual dated June 20, 2024, was reviewed and lacked the following required content: -EP Program Patient Population -Process for EP Collaboration -Subsistence needs for Staff and Patients -Policies and Procedures for Volunteers -Emergency Prep Testing Requirements On September 17, 2024, at 10:30 a.m. licensed assisted living director (LALD)-A and administrator (A)-D reviewed the emergency preparedness manual with the surveyor and verified the missing content. The licensee's Emergency Preparedness Policy dated February 10, 2022, indicated the policy references CMS State Operations Manual Appendix Z; MN rules 4659.0100. No additional 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	0 780		

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0 780	Continued From page 4 for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide a smoke alarm on the attic-level floor and failed to provide smoke alarms that are interconnected so that the activation of one alarm causes all alarms in the home to operate for proper notification. This has the potential to directly affect 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 the potential to affect a large portion or all of the residents). The findings include:	0 780		

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0 780	Continued From page 5 On September 18, 2024, from approximately, 10:00 a.m. to 11:00 a.m., survey staff toured the home with licensed assisted living director (LALD)-A. During the tour, survey staff observed the following: -A missing smoke alarm in the attic-level floor (with permanent stairs and a door) of the home. LALD-A advised survey staff that the attic level was not used. Survey staff explained that the attic level has a standard door for access and permanent stairs, it ' s considered another level of the home and is subject to smoke alarm requirements to ensure all levels of the home are protected. -The smoke alarms inside the upper-level resident sleeping rooms 3 and 4, and the upper-level hallway in the home were not interconnected so the actuation of one alarm would cause all alarms to operate and sound throughout as required. The above deficient findings were verbally and/or visually verified by LALD-A at the time of discovery accompanying the home tour. On September 18, 2024, at approximately 11:30 a.m., survey staff explained the above deficient findings to LALD-A during the exit interview. They acknowledged the findings and had no further questions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment	0 800		

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0 800	Continued From page 6 (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of the residents, visitors, 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, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 18, 2024, from approximately, 10:00 a.m. to 11:00 a.m., survey staff toured the home with licensed assisted living director (LALD)-A. During the home tour, survey staff observed the following: -The furnace filter was filled with thick dust and/or dirt. LALD-A confirmed the finding and stated he would buy a new filter and replace it.	0 800		

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0 800	Continued From page 7 -The clothes dryer exhaust duct was disconnected near the basement ceiling where survey staff observed a significant accumulation of lint and dust near the exhaust duct areas and the wall. LALD-A confirmed the finding at the time of discovery. LALD-A stated the exhaust duct must have been disconnected recently. -The main level bathroom had a hose with handheld spray connected to the home ' s water piping without an approved backflow preventer to prevent cross-connection and contamination of the water supply system. The handheld spray had a control valve downstream that hung on the side of the toilet tank and the hose was connected to the home's water supply pipe that also served the toilet bowl. Survey staff explained to LALD-A that the improper water supply pipe installation compromises the drinking water supply system. Plumbing installation including connecting to the home ' s water system must be provided with a code-approved backflow preventer and be installed by a licensed plumbing by the state regulations. -Missing window screens in resident rooms 1 and 2. -Lack of cleaning and maintenance on the upper-level bathroom. The bathtub had dark stains on the perimeters where the tub meets the wall. The above deficient findings were verbally and/or visually verified by LALD-A at the time of discovery. On September 18, 2024, at approximately 11:30 a.m., during an interview, the survey staff explained the above deficient conditions to LALD-A and he acknowledged the findings. No further information was provided.	0 800		

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0 800	Continued From page 8 TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=B	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 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 9 This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide the minimum number of fire evacuation drills for calendar year 2023. This has the potential to directly affect the safety staff and all residents. 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 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 September 18, 2024, at approximately 11:00 a.m., document and record review and interview with licensed assisted living director (LALD)-A, on the home's fire safety and evacuation plan, and related training policies, procedures, and records. Record review indicated the licensee failed to provide the minimum required employee fire evacuation drills twice per year, per shift with at least one evacuation drill every other month for the calendar year 2023. Survey staff received correct records for review to date for the year 2024, but lacked records for 2023. Survey staff received one paper record (January 20, 2023) with a drill record covering two shifts. LALD-A confirmed the finding and immediately placed a telephone call to their consultant requesting electronic copies of the 2023 evacuation drills.	0 810		

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0 810	Continued From page 10 LALD-A stated that the 2023 evacuation drill records will be provided to survey staff by 3:30 p.m. (September 18, 2024). No additional records were received. The above deficient finding was verified by LALD-A during the interview. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 810		
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 ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide the minimum state standard-sized egress windows for unoccupied resident sleeping room 4. This had the potential	0 820		

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0 820	Continued From page 11 to affect resident (s) 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, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On September 18, 2024, from approximately, 10:00 a.m. to 11:00 a.m., survey staff toured the home with licensed assisted living director (LALD)-A. Survey staff observed the clear window openings of the double-hung windows in unoccupied sleeping room 4 on the upper-level floor did not meet the minimum state-standard size egress window requirement. LALD-A opened the maximum openable window with opening dimensions, height at 27.5 inches, and width at 23.25 inches, totaling an area opening size of 639.75 inches, which did not meet the required minimum total clear window opening area of 648 inches. Existing egress window openings must meet a minimum clear opening area of 648 square inches and have minimum dimensions of 20 inches in height and 20 inches in width. The above finding was verbally verified with LALD-A accompanying the tour. On September 18, 2024, at approximately 11:30 a.m., during an interview, survey staff again	0 820		

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	37495	A. BUILDING: _____ B. WING _____	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED SOCIAL SERVICE OF MN	1020 EAST 25TH STREET MINNEAPOLIS, MN 55404

(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
0 820	Continued From page 12 explained the above finding to LALD-A and they acknowledged the finding. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 820		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident. 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:	0 970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37495	A. BUILDING: _____ B. WING _____	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED SOCIAL SERVICE OF MN	1020 EAST 25TH STREET MINNEAPOLIS, MN 55404

(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
0 970	Continued From page 13 R2 started receiving services from the licensee on February 8, 2023. R2's contract dated February 7, 2023, included language the resident would waive the licensee's liability for health, safety, or personal property of a resident. The liability clause indicated the resident agreed to be liable and responsible for all obligations herein referenced, monetary and otherwise, of the resident and where this contract has been executed by a party designated below. On September 16, 2024, at 2:41 p.m., licensed assisted living director (LALD)-A and administrator (A)-D stated they were aware the contract language regarding liability was incorrect. A-D stated they used home care consultants and have the 2022 version. They were working on an updated contract, and will send it out to all residents to sign when it was completed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		

Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul
6512014500

Type: Full
Date: *09/16/24*
Time: 13:52:48
Report: 1029241322

Food and Beverage Establishment Inspection Report

Location:

United Social Service Of Mn
1020 East 25th Street
Minneapolis, MN55404
Hennepin County, 27

Establishment Info:

ID #: 0038682
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 9523815927
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.

2-300 Personal Cleanliness

2-301.12B ***** Priority 1 *****

MN Rule 4626.0070B Food employees must use the following procedure when cleaning their hands and exposed portions of their arms: rinse their hands under clean, warm running water; apply hand soap to their hands; rub their hands together vigorously for at least 10 to 15 seconds; remove soil from beneath fingernails while cleaning their hands; thoroughly rinse their hands under clean, warm running water; and thoroughly dry their hands with: 1) individual, disposable towels, 2) a continuous towel system that supplies the user with a clean towel, 3) a heated-air hand drying device, or 4) a hand drying device that employs an air-knife system that delivers high velocity, pressurized air at ambient temperatures.

INCORRECT HANDWASHING DURATION AND STEPS. EXAMPLE PROVIDED DURING INSPECTION.

Comply By: 09/16/24

3-500B Microbial Control: hot and cold holding

3-501.16A2 ***** Priority 1 *****

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

SHELL EGGS IN DANGER ZONE IN REFRIGERATOR. DISCARDED BY REP. STAFF ACTIONS AND EQUIPMENT OPERATION DISCUSSED FOR TEMP CONTROL. REP INSTRUCTED TO VERIFY SAFE TEMPS IN COOLER AND MODIFY ACTIONS TO MAINTAIN TEMP CONTROL.

Comply By: 09/16/24

Type: Full
Date: *09/16/24*
Time: 13:52:48
Report: 1029241322
United Social Service Of Mn

Food and Beverage Establishment Inspection Report

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.111C ***** Priority 2 *****

MN Rule 4626.1565C Use approved trapping devices or other means of pest control when pests are found.

RODENT DROPPINGS IN KITCHEN. ESTABLISHMENT USING PEST CONTROL COMPANY. REP INSTRUCTED TO REMOVE DROPPINGS, CLEAN AND SANITIZE, AND TO USE PEST CONTROL TO REDUCE AND ELIMINATE RODENT PRESENCE.

Comply By: 09/20/24

Food and Equipment Temperatures

Process/Item: COLD HOLD/MILK
Temperature: 43 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

Process/Item: COLD HOLD/SHELL EGG
Temperature: 58 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: Yes

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

Establishment is residential in nature with two kitchen areas, one upstairs and one downstairs, but only the downstairs kitchen area is used. Establishment's lower kitchen area has faux-wood laminate flooring, wood/composite-wood drawers and cabinetry, stone-like countertops, smooth painted walls and ceiling. Some interior holding surfaces in cabinetry missing laminate coverings thereby leaving MDF exposed. Establishment uses NSF 184 standard dishwasher to high-heat sanitize and thermal stickers to verify temps of 160-180F. Identified issues addressed with operator during inspection.

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 1029241322 of 09/16/24.

Certified Food Protection Manager: ABDUKADIR M. NOR

Certification Number: FM107981 Expires: 08/02/27

Inspection report reviewed with person in charge and emailed.

Signed: _____
ABDUKADIR M. NOR
LALD

Signed: Trevor McCliment
Trevor McCliment
Public Health Sanitarian
Metro District Office
651-201-3957
trevor.mccliment@state.mn.us

Report #: 1029241322

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul

No. of RF/PHI Categories Out	2	Date	09/16/24
No. of Repeat RF/PHI Categories Out	0	Time In	13:52:48
Legal Authority MN Rules Chapter 4626		Time Out	

United Social Service Of Mn	Address: 1020 East 25th Street	City/State: Minneapolis, MN	Zip Code: 55404	Telephone: 9523815927
License/Permit #: 0038682	Permit Holder	Purpose of Inspection: Full	Est Type	Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

	Compliance Status		COS	R
	Supervision			
1	(IN) OUT	PIC knowledgeable; duties & oversight		
2	(IN) OUT N/A	Certified food protection manager, duties		
	Employee Health			
3	(IN) OUT	Mgmt/Staff;knowledge,responsibilities&reporting		
4	(IN) OUT	Proper use of reporting, restriction & exclusion		
5	(IN) OUT	Procedures for responding to vomiting & diarrheal events		
	Good Hygenic Practices			
6	IN OUT (N/O)	Proper eating, tasting, drinking, or tobacco use		
7	(IN) OUT N/O	No discharge from eyes, nose, & mouth		
	Preventing Contamination by Hands			
8	IN (OUT) N/O	Hands clean & properly washed		
9	IN OUT N/A (N/O)	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	(IN) OUT	Adequate handwashing sinks supplied/accessible		
	Approved Source			
11	(IN) OUT	Food obtained from approved source		
12	IN OUT N/A (N/O)	Food received at proper temperature		
13	(IN) OUT	Food in good condition, safe, & unadulterated		
14	IN OUT (N/A) N/O	Required records available; shellstock tags, parasite destruction		
	Protection from Contamination			
15	(IN) OUT N/A N/O	Food separated and protected		
16	(IN) OUT N/A	Food contact surfaces: cleaned & sanitized		
17	(IN) OUT	Proper disposition of returned, previously served, reconditioned, & unsafe food		

	Compliance Status		COS	R
	Time/Temperature Control for Safety			
18	IN OUT N/A (N/O)	Proper cooking time & temperature		
19	IN OUT N/A (N/O)	Proper reheating procedures for hot holding		
20	IN OUT N/A (N/O)	Proper cooling time & temperature		
21	IN OUT (N/A) N/O	Proper hot holding temperatures		
22	IN (OUT) N/A	Proper cold holding temperatures		
23	IN OUT N/A (N/O)	Proper date marking & disposition		
24	IN OUT (N/A) N/O	Time as a public health control: procedures & records		
	Consumer Advisory			
25	IN OUT (N/A)	Consumer advisory provided for raw/undercooked food		
	Highly Susceptible Populations			
26	(IN) OUT N/A	Pasteurized foods used; prohibited foods not offered		
	Food and Color Additives and Toxic Substances			
27	IN OUT (N/A)	Food additives: approved & properly used		
28	(IN) OUT	Toxic substances properly identified, stored, & used		
	Conformance with Approved Procedures			
29	IN OUT (N/A)	Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
		Safe Food and Water		
30	IN OUT (N/A)	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT (N/A)	Variance obtained for specialized processing methods		
		Food Temperature Control		
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT (N/A) N/O	Plant food properly cooked for hot holding		
35	IN OUT N/A (N/O)	Approved thawing methods used		
36		Thermometers provided & accurate		
		Food Identification		
37		Food properly labled; original container		
		Prevention of Food Contamination		
38	X	Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
		Proper Use of Utensils		
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
		Utensil Equipment and Vending		
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
		Physical Facilities		
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) [signature] **Date:** 09/16/24

Inspector (Signature) Trevor McCliment