DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

August 5, 2022

Administrator
MINN CARE HOME HEALTH
7055 Perry Avenue North
Brooklyn Center, MN 55429

RE: Project Number SL37065015

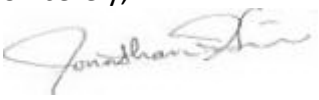
Dear Administrator:

On July 29, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the May 3, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,



Jonathan Hill, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
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St. Paul, MN 55101-3879
Email: jonathan.hill@state.mn.us
Telephone: 651-592-5119 Fax: 651-215-9697

HHH

Electronically Delivered

May 23, 2022

Administrator
Minn Care Home Health
7055 Perry Avenue North
Brooklyn Center, MN 55429

RE: Project Number(s) SL37065015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on May 3, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health 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.

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

IMPOSITION OF FINES
In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this evaluation:

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program = $500.00

The total amount you are assessed is $500.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction 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 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 licensing 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 general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:	Free from Maltreatment reconsideration requests should be addressed to:

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

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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Jess Gallmeier, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-247-0268 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37065	A. BUILDING: _____ B. WING _____	05/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINN CARE HOME HEALTH	7055 PERRY AVENUE NORTH BROOKLYN CENTER, MN 55429

(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 Initial comments ******ATTENTION****** 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: SL#37065015 On May 2, 2022, through May 3, 2022, 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, there were four (4) residents receiving services under the provider's Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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.	
0 510 SS=F	144G.41 Subd. 3 Infection control program	0 510		

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0 510	Continued From page 1 (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to establish and maintain an effective infection control program that complies with accepted health care, medical and nursing standards for infection control related to COVID-19. The licensee failed to ensure staff and visitors entering or re-entering the building were screened for COVID-19 with documented temperatures and symptom screening questions. The licensee failed to ensure staff wore face masks and eye protection while working in the building. This had the potential to affect all four 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, 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).	0 510		

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0 510	Continued From page 2 The findings include: COVID-19 Screening & Personal Protective Equipment On May 2, 2022, at approximately 9:30 a.m., the surveyor knocked on the licensee's main door. Unlicensed personnel (ULP)-B opened the door, but she was not wearing a face mask or eye protection. In addition, ULP-B did not screen the surveyor for signs and symptoms of COVID-19 and or document the surveyor's temperature. On May 2, 2022, at approximately 9:50 a.m., during the entrance conference registered nurse (RN)-A, licensed assisted living director (LALD)-C and secondary licensed assisted living director (SLALD)-D did not have face masks and eye protection on. On May 2, 2022, at approximately 10:30 a.m., a state engineering surveyor entered the building. The surveyor was not screened for signs and symptoms of COVID-19 and temperature documented. On May 2, 2022, at approximately 10:40 a.m., the surveyor requested records for residents' signs and symptoms screenings for COVID-19 and temperature documentation for the month of April 2022. SLALD-D stated the licensee used to document but stopped. On May 2, 2022, at approximately 10:45 a.m., SLALD-D stated the licensee was following the State of Minnesota's recommendation to have masks and eye protections optional indoors. On May 2, 2022, at approximately 10:58 a.m., the Centers for Disease Control and Prevention (CDC) Covid-19 data tracker current status	0 510		

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0 510	Continued From page 3 indicated the community transmission level was high in the licensee's county and recommended facemasks and eye protection be worn. The Minnesota Department of Health COVID-19 Personal Protective Equipment (PPE) Grid for Congregate Care Settings by Community Transmission Level dated April 7, 2022, indicated health care workers (HCW) to wear well-fitting medical grade facemask and eye protection when community transmission rates are high. The licensee's Infection Control policy dated January 1, 2020, indicated the licensee's staff will ensure standard precautions are maintained when providing services to residents. The licensee's policy lacked verbiage for Covid-19 precautions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 630 SS=D	144G.42 Subd. 6 Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse.	0 630		

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0 630	Continued From page 4 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan was developed to include person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse for one of one resident (R1) with record 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) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1's diagnoses included major depressive disorder, type one diabetes mellitus without complications, type two diabetes without complications and acute kidney failure. R1's service plan dated February 6, 2022, indicated R1 was receiving services to include behavior management, laundry, medication administration, diabetic care, and shopping assistance. R1's Individual Abuse Prevention Plan (IAPP) dated January 26, 2022, identified vulnerabilities to include depression, risk to be abused by others, transportation, and management environment. R1's IAPP lacked an assessment for the R1's risk of abusing other vulnerable adults and statements of the specific measures to	0 630		

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0 630	Continued From page 5 be taken to minimize the risk of abuse to the resident and other vulnerable adults. On May 3, 2022, at approximately 11:20 a.m., licensed assisted living director (LALD)-C, stated the assessment is completed for all residents on admission. LALD-C also stated the template in R-Task software guided the assessment process. The licensee' undated Individual Abuse Prevention Plan policy indicated IAPPs shall be developed for each new person as part of initial service plan, also indicated the plan shall include statements of measures that will be taken to minimize the risk of abuse to the vulnerable adult. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced	0 640		

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0 640	Continued From page 6 by: Based on observation and interview, the licensee failed to support protection and safety by not posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) and failed to post the 911 emergency number in common areas and near telephones provided by the assisted living. This had the potential to affect all four (4) residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients). The findings include: On May 2, 2022, at approximately 10:45 a.m., during a facility tour, the surveyor did not observe the required posting of the emergency number and information related to reporting suspected maltreatment to MAARC in the licensee's common areas. During an interview on May 2, 2022, at approximately 12:29 p.m., licensed assisted living director (LALD)-C acknowledged the required information was not posted in the common areas of the licensee's facility. The licensee's policy for reporting maltreatment was requested but not provided. No further information was provided.	0 640		

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0 640	Continued From page 7 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant 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 plan with all the required content.	0 680		

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0 680	Continued From page 8 This had the potential to affect all staff, visitors, and residents receiving services under 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 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 May 2, 2022, at approximately 9:50 a.m., during the entrance conference, the surveyor requested to review the licensee's emergency preparedness plan. The licensee's emergency preparedness plan lacked evidence of the following required content: - a description of the population served by the licensee; - process for emergency preparedness (EP) cooperation with state and local EP officials/organizations; - procedure for tracking staff and residents; - subsistence needs for staff and residents during emergency situation; - development of policies/procedures to address: - evacuation plan (not customized for the facility); - fire (not customized for the facility); - shelter in place; - a tracking system used to document locations or residents and staff; - the medical record documentation system to preserve resident information;	0 680		

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0 680	Continued From page 9 - emergency staff strategies; and - the facilities role in providing care and treatment at alternative sites; - a communication plan that included: - arrangement with other facilities; - names and contact information for staff, resident physicians, other facilities; - contact information for federal, state, tribal, local EP staff, ombudsman; - primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management agencies; - a method of sharing information and medical documentation for residents; - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy; and -a method of sharing information from the emergency plan with residents and their families; - EP training and testing program; - EP training program for staff (including documentation of training provided); and - EP testing/annual testing requirements. On May 3, 2022, at approximately 12:10 p.m., licensed assisted living director (LALD)-C acknowledged the EP plan was missing the required content and stated the licensee will update their records to reflect the required content. The licensee's Disaster Planning and Emergency Preparedness Plan policy dated October 1, 2021, indicated the licensee will have in place a written emergency and disaster plan, signage, directions, training, and drills. The plan lacked the verbiage to include the required content.	0 680		

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0 680	Continued From page 10 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents). The findings include: On May 02, 2022, from approximately 10:30 a.m. to 11:00 a.m., survey staff toured the facility with the licensed assisted living director (LALD)-C.	0 800		

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	37065	A. BUILDING: _____ B. WING _____	05/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINN CARE HOME HEALTH	7055 PERRY AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 800	Continued From page 11 During the facility tour, survey staff observed significant damage to the upstairs bathroom door frame and door. The sealant around the toilet was stained and missing in some areas. The grout in the maintenance nook of the bathroom had large areas that were damaged or missing. This could lead to water getting under the tiles and rotting the subfloor. LALD-C verbally confirmed survey staff observations during the facility tour. He stated that the electric scooter of one of the residents was damaging the walls, doors, and door frames throughout the facility. Damaged surfaces can lead to injury and must be repaired and maintained. The licensee did not have a maintenance plan for the upstairs bathroom. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) 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	0 810		

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0 810	Continued From page 12 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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide the required fire safety training and evacuation plans for residents and staff. This has the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 residents).	0 810		

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0 810	Continued From page 13 The findings include: During interview on May 02, 2022, at 11:00 a.m., the licensed assisted living director (LALD)-C stated they were doing fire safety and evacuation training for staff upon hire and training for staff and residents at every in-service training day. LALD-C stated that in-service training days happen every two months. The facility did not have the correct number of fire drills completed. Review of the fire safety policy showed the following: 1. Record of required employee evacuation drills was inaccurate and stated that fire drills should occur two to three times a year. No record of completed fire drills. 2. Policy and procedures indicated the facility had a shelter-in-place fire safety plan. The facility did not have any life safety measures in place to allow for a shelter-in-place plan. 3. No schedule or records on the training of employees on fire safety and evacuation; on proper actions to take in the event of a fire or emergency for the safety of residents including movement, evacuation, or relocation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 950 SS=F	144.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify	0 950		

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0 950	Continued From page 14 a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident was given opportunity to identify a designated representative for one of one resident (R1) with record 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) and was issued at a widespread scope (when problems are pervasive	0 950		

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0 950	Continued From page 15 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: R1 was admitted on January 26, 2022, to receive assisted living services. R1's Assisted Living Contract dated January 26, 2022, included a section 'designation of representative,' which neither indicated who R1's designated representative was or that R1 declined to appoint one. On May 2, 2022, at approximately 2:35 p.m., licensed assisted living director (LALD)-C acknowledged R1 was denied the opportunity to designate a representative and stated none of the licensee's residents had appointed a representative or initialed an acknowledgement to decline the same. The licensee's Assisted Living Contract policy, dated August 1, 2021, indicated the verbatim notice would be provided to each resident at the time of contract execution. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
0 970 SS=F	144.50 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	0 970		

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0 970	Continued From page 16 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 the health, safety, or personal property of a resident. This had the potential to affect all four 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 of the residents). The findings include: R1's record included a copy of the Assisted Living Contract, dated January 26, 2022. R1's Assisted Living Contract included a section titled Indemnification. The section indicated R1 waived liability (responsibility) of the licensee for the health and safety or personal property of a resident. On May 2, 2022, at approximately 2:20 p.m., licensed assisted living director (LALD)-C acknowledged the licensee's assisted living contract included a waiver of the licensee's liability for health and safety or personal property. LALD-C also acknowledged the same contract is	0 970		

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0 970	Continued From page 17 used for all the licensee's residents. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01490 SS=F	144G.63 Subd. 4 Training required relating to dementia All direct care staff and supervisors providing direct services must demonstrate an understanding of the training specified in section 144G.64. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff received dementia training in the required areas for three of three employees (registered nurse (RN)-A, unlicensed personnel (ULP)-B, ULP-E) 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), 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 transitioned from a comprehensive home care to an assisted living on August 1, 2021.	01490		

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01490	Continued From page 18 RN-A started employment with licensee on December 30, 2021. ULP-B started employment with licensee on August 25, 2021. ULP-E started employment with licensee on July 26, 2021. RN-A, ULP-B and ULP-E's employee files lacked evidence of completing dementia care training in the topics; - an explanation of Alzheimer's disease and other dementias; - assistance with activities of daily living; - problem solving with challenging behaviors; - communication skills; and - person-centered planning and service delivery. On May 3, 2022, at approximately 11:45 a.m., secondary licensed assisted living director (SLALD)-D acknowledged the employee files were missing dementia care training and stated the licensee thought because they did not care for any dementia patients the dementia education was not necessary. In addition, SLALD-D stated none of the licensee's employee had dementia training. The licensee's Dementia Training policy dated January 1, 2020, indicated the licensee's employees are required to complete dementia training at the time of hire and annually thereafter. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty One (21) days	01490		

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01620	Continued From page 19	01620		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted ongoing resident monitoring and reassessment 14 calendar days from the initial assessment for one of one resident (R1) with record 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	01620		

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01620	Continued From page 20 resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 admitted to licensee on January 26, 2022. R1's service plan dated February 6, 2022, indicated R1 received services to include behavior management, laundry, medication administration, diabetic care, and shopping assistance. R1's record included an initial assessment completed on January 26, 2022, and a subsequent assessment completed on April 25, 2022. R1's record lacked a reassessment and monitoring conducted no more than 14 calendar days after initiation of services. On May 2, 2022, at approximately 12:30 p.m., licensed assisted living director (LALD)-C acknowledged a 14-day assessment had not been completed for R1. LALD-C further stated the RN missed the assessment as the licensee did not have a tracking system in place, which they have now. The licensee's undated Assessment, Monitoring and Reassessment policy indicated resident monitoring and reassessment must conducted no more than 14 days after initiation of services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		

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01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes.	01730		

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01730	Continued From page 22 (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop an individualized medication management record with the required content for one of one resident (R1) with record 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 potential to affect a large portion or all of the residents). The findings include: On May 3, 2022, at approximately 8:40 a.m., unlicensed personnel (ULP)-E administered morning medications to R1. R1's service plan dated February 6, 2022, indicated R1 received services to include behavior management, laundry, medication management, diabetic care, and shopping assistance. R1's individualized medication management record dated January 26, 2022, lacked the following required content to include: - a description of storage of medications based	01730		

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01730	Continued From page 23 on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; - documentation of specific resident instructions relating to the administration of medications; - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; - identification of medication management tasks that may be delegated to unlicensed personnel; - procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and - any resident-specific requirements relating to documenting medication administration On May 3, 2022, at approximately 12:10 p.m., licensed assisted living director (LALD)-C acknowledged R1's individualized medication management record was missing the above content. LALD-C also stated the same template is used for all residents. In addition, LALD-C stated the registered nurse completes medication assessment frequently and the unlicensed personnel are trained. The licensee's Medication Management policy dated April 1, 2020, indicated the licensee will safely and correctly provide medication administration to residents. The policy lacked the verbiage to include individualized medication management plan content. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		

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01880	Continued From page 24	01880		
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to store all prescription medications according to the manufacturer's directions for one of one resident (R1) with record 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) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On May 3, 2022, at approximately 8:00 a.m., unlicensed personnel (ULP)-B administered Humalog Kwik pen (insulin injection) 12 units. On May 3, 2022, at approximately 9:10 a.m., the surveyor observed the contents of the medication refrigerator that included: Humalog (insulin Lispro injection) two pens each 100 unit/milliliter (ml), and Lantus (glargine injection) 100 units/ml two unopened boxes. The refrigerator did not have a thermometer and lacked a daily temperature log. R1's diagnoses included major depressive	01880		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINN CARE HOME HEALTH	7055 PERRY AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01880	Continued From page 25 disorder, type one diabetes mellitus without complications, type 2 diabetes without complications and acute kidney failure. The manufacturer's instructions for Lantus insulin pens indicated before opening store the insulin pens in the refrigerator (36-46 degrees F), but do not freeze it. The manufacturer's instruction for Humalog (insulin Lispro) should be stored in the refrigerator (36° to 46°F) until it is opened, but do not freeze it. On May 3, 2022, at approximately 9:30 a.m., licensed assisted living director (LALD)-C acknowledged the refrigerator was missing a thermometer and stated the licensee will implement a daily log once they have a thermometer. The licensee's Storage of Medications policy dated January 1, 2020, indicated medications shall be stored consistent with manufacturer's recommendations (refrigerator, room temperature or frozen). No further information was provided. TIME PERIOD TO CORRECT: Seven (7) days	01880		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37065	A. BUILDING: _____ B. WING _____	05/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINN CARE HOME HEALTH	7055 PERRY AVENUE NORTH BROOKLYN CENTER, MN 55429

(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
01910	Continued From page 26	01910		

discontinued or have expired may be provided for disposal.
(b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances.
(c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure medications discontinued had been disposed of properly and documented in the resident's record, for one of one resident (R2) with record 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) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).

The findings include:

R2 was discharged from the assisted living on February 15, 2022.

R2's discharge summary dated February 15, 2022, indicated the licensee was managing the

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	37065	A. BUILDING: _____ B. WING _____	05/03/2022

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MINN CARE HOME HEALTH	7055 PERRY AVENUE NORTH BROOKLYN CENTER, MN 55429

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01910	Continued From page 27 following medications: -acamprosate calcium 333 milligram (mg) -amlodipine besylate 5 mg -aripiprazole 2 mg -Certavite -docusate sodium -folic acid 1 gram -gabapentin 400 mg -levothyroxine sodium 75 microgram (mcg) -pantoprazole sodium 40 mg -propranolol hcl 20 mg -quetiapine fumarate 300 mg -tizanidine hcl 4 mg, and -albuterol sulfate 108 mcg. R2's discharge record lacked a medication disposition record to include the following content: medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. On May 2, 2022, at approximately 10:35 a.m., licensed assisted living director (LALD)-C acknowledged R2's record was missing a medication disposition record. LALD-C also stated the licensee was still keeping R2's medications awaiting communication from R2's case manager. The licensee's Disposal of Medication policy dated January 1, 2020, indicated the licensee will dispose any medication as needed in a proper way following guidelines of the Minnesota Board of Pharmacy. Also, the policy indicated the licensee will maintain the disposition record with the content above. No further information was provided.	01910		

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	37065	A. BUILDING: _____ B. WING _____	05/03/2022

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01910	Continued From page 28 TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced	01940		

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	37065	A. BUILDING: _____ B. WING _____	05/03/2022

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MINN CARE HOME HEALTH	7055 PERRY AVENUE NORTH BROOKLYN CENTER, MN 55429

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01940	Continued From page 29 by: Based on observation, interview and record review, the licensee failed to develop a treatment management plan to include all required content for one of one resident (R1) with blood glucose monitoring. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On May 3, 2022, at approximately 8:40 a.m., unlicensed personnel (ULP)-E administered morning medications to R1. In addition, ULP-B stated the blood glucose checked that morning was 438. R1's service plan dated February 6, 2022, indicated R1 received services to include behavior management, laundry, medication management, diabetic care, and shopping assistance. R1's record lacked treatment management plan to include the following content: -a statement of the type of services that will be provided; -documentation of specific resident instructions relating to the treatment or therapy administration; -identification of the treatment or therapy that will be delegated to unlicensed personnel;	01940		

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	37065	A. BUILDING: _____ B. WING _____	05/03/2022

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MINN CARE HOME HEALTH	7055 PERRY AVENUE NORTH BROOKLYN CENTER, MN 55429

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01940	Continued From page 30 -procedures for notifying a nurse or appropriate licensed health professional when a problem arises with the treatments or therapy services; and -any resident-specific requirements relating to documentation of treatment and therapy received and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On May 3, 2022, at approximately 12:10 p.m., licensed assisted living director (LALD)-C acknowledged R1's individualized treatment management record was missing the above content, and stated the licensee will update their records to include the missing content. The licensee's Medication & Treatment Orders policy dated January 1, 2020, lacked the verbiage to include the content of treatment management plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
02240 SS=F	144G.90 Subdivision 1 Assisted living bill of rights; notification (a) An assisted living facility must provide the resident a written notice of the rights under section 144G.91 before the initiation of services to that resident. The facility shall make all reasonable efforts to provide notice of the rights to the resident in a language the resident can understand. (b) In addition to the text of the assisted living bill of rights in section 144G.91, the notice shall also contain the following statement describing how to	02240		

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02240	Continued From page 31 file a complaint or report suspected abuse: "If you want to report suspected abuse, neglect, or financial exploitation, you may contact the Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about the facility or person providing your services, you may contact the Office of Health Facility Complaints, Minnesota Department of Health. You may also contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities." (c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, e-mail address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities. The statement must include the facility's name, address, e-mail, telephone number, and name or title of the person at the facility to whom problems or complaints may be directed. It must also include a statement that the facility will not retaliate because of a complaint. (d) A facility must obtain written acknowledgment from the resident of the resident's receipt of the assisted living bill of rights or shall document why an acknowledgment cannot be obtained. Acknowledgment of receipt shall be retained in the resident's record. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current Minnesota Bill of Rights for Assisted Living Residents was provided to all the four assisted living residents	02240		

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02240	Continued From page 32 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 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: During the entrance conference, licensed assisted living director (LALD)-C provided the surveyor with a blank new resident open packet, which contained a Minnesota Home Care Bill of Rights for Assisted Living Clients of Licensed Only Home Care Providers (revised November 2019). On May 2, 2022, at approximately 11:30 a.m., LALD-C acknowledged the licensee's four residents had received the wrong version of the bill of rights (BOR). In addition, LALD-C stated the licensee will update the residents' records to reflect the current BOR dated May 16, 2021. The licensee lacked a policy for Minnesota Bill of Rights for Assisted Living Residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02240		

Minnesota Department of Health

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

Type: Full
Date: *05/03/22*
Time: 13:00:00
Report: 8087221121

Food and Beverage Establishment Inspection Report

Location:
Minn Care Home Health
7055 Perry Avenue North
Brooklyn Center, MN55429
Hennepin County, 27

Establishment Info:
ID #: 0038509
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7632006270
ID #:

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

No NEW orders were issued during this inspection.

Food and Equipment Temperatures

Process/Item: Ambient Air
Temperature: 39 Degrees Fahrenheit - Location: WHIRLPOOL FRIDGE
Violation Issued: No

Process/Item: Cold Holding: MILK
Temperature: 39 Degrees Fahrenheit - Location: WHIRLPOOL FRIDGE
Violation Issued: No

Process/Item: Cold Holding: EGGS
Temperature: 40 Degrees Fahrenheit - Location: WHIRLPOOL FRIDGE
Violation Issued: No

Process/Item: Cold Holding: SOUR CREAM
Temperature: 39 Degrees Fahrenheit - Location: WHIRLPOOL FRIDGE
Violation Issued: No

Process/Item: Ambient Air
Temperature: 14 Degrees Fahrenheit - Location: WHIRLPOOL FREEZER
Violation Issued: No

Process/Item: Ambient Air
Temperature: 19 Degrees Fahrenheit - Location: CHEST FREEZER
Violation Issued: No

Type: Full
Date: *05/03/22*
Time: 13:00:00
Report: 8087221121
Minn Care Home Health

Food and Beverage Establishment Inspection Report

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

THIS WAS AN ANNOUNCED AND SCHEDULED FULL INSPECTION.

INSPECTION CONDUCTED IN THE PRESENCE OF NURSE EVALUATOR II BENARD NYANGENA. (HRD SURVEY SENIOR SUPERVISOR).

FLOORS AND CABINETS ARE HARDWOOD AND CEILING APPEARS TO BE DURABLE, BUT NOT EASILY CLEANABLE OR SMOOTH (POPCORN STYLE CEILING TEXTURE). ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

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

HOT WATER TEMPERATURE AT THE KITCHEN SINK REACHED 127 DEGREES.

INSPECTION REPORT EMAILED TO NURSE EVALUATOR II BENARD NYANGENA.

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 8087221121 of 05/03/22.

Certified Food Protection Manager: IKE DIJEH

Certification Number: FM107375 Expires: 07/27/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
IKE DIJEH
ASSISTED LIVING DIRECTOR

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