



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

December 20, 2024

Licensee
Kubra Home Care Inc.
2437 15th Avenue South
Minneapolis, MN 55404

RE: Project Number(s) SL33123015

Dear Licensee:

On November 18, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine the correction of orders from the February 7, 2024, survey and follow-up survey completed on April 26, 2024. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in blue ink, appearing to read 'Jess Schoenecker'.

Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

JMD



Protecting, Maintaining and Improving the Health of All Minnesotans

AMENDED

Electronically Delivered

June 11, 2024

Licensee
Kubra Home Care Inc
2437 15th Avenue South
Minneapolis, MN 55404

RE: Project Number(s) SL33123015

Dear Licensee:

On April 26, 2024, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on February 7, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the February 7, 2024 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on February 7, 2024, found not corrected at the time of the April 26, 2024, follow-up survey and/or subject to penalty assessment are as follows:

0800-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (4) - \$500.00

0810-Fire Protection And Physical Environment-144g.45 Subd. 2 (b)-(f) - \$500.00

The details of the violations noted at the time of this follow-up survey completed on April 26, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Also, at the time of this follow-up survey completed on April 26, 2024, we identified the following violation(s):

0100-License Required-144g.10 Subdivision 1

The details of the violation(s) noted at the time of this follow-up survey are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these state correction orders. It is not necessary to develop a plan of correction.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$1,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

IMPOSITION OF FINES:

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.

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.

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

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

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

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

INFORMAL CONFERENCE

At any time, the Commissioner of Health is authorized by Minn. Stat. § 144G.20, subd. 20 to hold an informal conference to exchange information, clarify issues, or resolve issues. The Minnesota Department of Health staff would like to schedule a conference call with Kubra Home Care Inc.

Please contact Jess Schoenecker directly at 651-201-3789, on or before Monday, July 17, 2024, to schedule the conference call.

We urge you to review these orders carefully. If you have questions, please contact Jess Schoenecker at 651-201-3789.

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

Sincerely,

A handwritten signature in black ink, appearing to read 'Jess Schoenecker', is positioned above the typed name and title.

Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

HHH



Protecting, Maintaining and Improving the Health of All Minnesotans

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June 11, 2024

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RE: Project Number(s) SL33123015

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0810-Fire Protection And Physical Environment-144g.45 Subd. 2 (b)-(f) - \$500.00

The details of the violations noted at the time of this follow-up survey completed on April 26, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Also, at the time of this follow-up survey completed on April 26, 2024, we identified the following violation(s):

0100-License Required-144g.10 Subdivision 1

The details of the violation(s) noted at the time of this follow-up survey are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these state correction orders. It is not necessary to develop a plan of correction.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$1,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to

comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

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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.

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.

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

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

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

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

Sincerely,

A handwritten signature in black ink, appearing to read "Tim Hanna". The signature is written in a cursive, flowing style.

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

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33123	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/26/2024
NAME OF PROVIDER OR SUPPLIER KUBRA HOME CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 2437 15TH AVENUE SOUTH 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 *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: SL33123015-1 On April 24, 2024, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on February 07, 2024. At the time of the survey, there was 01 resident; 01 receiving services under the Assisted Living license. As a result of the follow-up survey, the following orders were reissued.	{0 000}			
0 100 SS=F	144G.10 Subdivision 1 License required (a)(1)Beginning August 1, 2021, no assisted living facility may operate in Minnesota unless it is licensed under this chapter. (2) No facility or building on a campus may provide assisted living services until obtaining the required license under paragraphs (c) to (e). (b)The licensee is legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. Nothing in this chapter shall in any way affect the rights and remedies available under other law.	0 100			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 100	Continued From page 1 (c) Upon approving an application for an assisted living facility license, the commissioner shall issue a single license for each building that is operated by the licensee as an assisted living facility and is located at a separate address, except as provided under paragraph (d) or (e). (d) Upon approving an application for an assisted living facility license, the commissioner may issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility. An assisted living facility license for a campus must identify the address and licensed resident capacity of each building located on the campus in which assisted living services are provided. (e) Upon approving an application for an assisted living facility license, the commissioner may: (1) issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility with dementia care, provided the assisted living facility for dementia care license for a campus identifies the buildings operating as assisted living facilities with dementia care; or (2) issue a separate assisted living facility with dementia care license for a building that is on a campus and that is operating as an assisted living facility with dementia care. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to obtain accurate licensure when the licensee applied for two licensures despite having a single building sharing one roof without having an approved two-hour fire barrier. This practice resulted in a level two violation (a	0 100			

Minnesota Department of Health

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0 100	Continued From page 2 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: The licensee's health facility identification (HFID) 33123 was located at 2437 15TH AVE S, Minneapolis, MN 55404, the upper level of the building, with 2435 15TH AVE S, Minneapolis, MN 55404 (HFID 33122) occupying the lower level of the building. On April 24, 2024, at 10:30 a.m., survey staff toured the facility with licensed assisted living director (LALD)-B. During the tour, survey staff observed the assisted living licensed facility was located in a building with two connected dwelling units, sharing the same roof, with separate entrances and separate addresses. The assisted living license requires a 2-hour fire barrier wall to separate the licensed assisted living facility from the other unit in the duplex. During an interview on April 24, 2024, at 12:30 p.m. LALD-B stated she did not know anything about a 2-hour fire barrier between the second and third levels of the building. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 100			

Minnesota Department of Health

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{0 110}	Continued From page 3	{0 110}			
{0 110} SS=C	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: No further action required.	{0 110}			
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: No further action required.	{0 480}			
{0 580} SS=C	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about	{0 580}			

Minnesota Department of Health

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{0 580}	Continued From page 4 quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: No further action required.	{0 580}			
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually 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	{0 680}			

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{0 680}	Continued From page 5 by: No further action required.	{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 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. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On April 24, 2024, at 10:30 a.m., survey staff	{0 800}			

Minnesota Department of Health

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{0 800}	Continued From page 6 toured the facility with licensed assisted living director (LALD)-B. The following was observed: It was observed in the upstairs bathroom that the lights were burned out. Survey staff attempted to turn on the light and fan using the light switch on the wall, but no light came on. LALD-B stated she did not know the light was burned out. It was observed in bedrooms #3 and #4 that the old J-box where previous smoke alarms were installed had been filled with paper towel. Any electrical removals must be properly capped and topped to avoid a fire hazard. It was observed that the water heaters in the basement were missing the overflow pipe that directed hot water to the floor. LALD-B visually verified these deficient findings at the time of discovery. During interview on April 24, 2024 at 12:30 p.m. LALD-B stated she understood the above listed deficiencies and would get them taken care of as soon as possible. No further information was provided.	{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;	{0 810}			

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{0 810}	Continued From page 7 (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. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. 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	{0 810}			

Minnesota Department of Health

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{0 810}	Continued From page 8 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 April 24, 2024, licensed assisted living director (LALD)-B provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee's FSEP, titled "Fire Safety", dated March, 18, 2024, failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The provided FSEP was from a third-party provider and had not been updated to the specific facility. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff	{0 810}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33123	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/26/2024
NAME OF PROVIDER OR SUPPLIER KUBRA HOME CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 2437 15TH AVENUE SOUTH 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
{0 810}	Continued From page 9 to follow in case of relocation. During an interview on April 24, 2024, at 12:30 p.m., LALD-B stated they had updated the policy and would email it to survey staff by the end of the day on April 24. Email was received on April 24, 2024 at 2:41 p.m. with the reviewed policy attached. The email attachment was an unedited policy purchased from a third-party provider that was not specific to the facility. The location of the fire extinguishers had been filled in, but no other changes had been made. The policy appeared to be a newer version of the policy reviewed on February 6, 2024 at the time of the initial survey. No further information was provided.	{0 810}			
{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: No further action required.	{0 970}			
{01060} SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a	{01060}			

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{01060}	Continued From page 10 resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process	{01060}			

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{01060}	Continued From page 11 in this section.currently known; and This MN Requirement is not met as evidenced by: No further action required.	{01060}			
{01500} SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and	{01500}			

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{01500}	Continued From page 12 (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: No further action required.	{01500}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

March 1, 2024

Licensee

Kubra Home Care Inc
2437 15th Avenue South
Minneapolis, MN 55404

RE: Project Number(s) SL33123015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 7, 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.

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

STATE CORRECTION ORDERS

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

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEphVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,



Renee Anderson, Supervisor

State Evaluation Team

Email: renee.anderson@state.mn.us

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

HHH

Minnesota Department of Health

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0 000	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: SL33123015-0 On February 5, 2024, through February 7, 2024, 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 was one resident receiving services under the 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 License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. 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 pursuant to 144G.31 Subd. 1, 2 and 3		
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services	0 110			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 110	Continued From page 1 and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record for the licensee through the Board of Executives for Long-Term Service and Supports (BELTSS) website. This had the potential to affect all the licensee's residents, staff, and visitors. 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 potential to affect a large portion or all the residents). The findings include: The licensee identified two LALDs for the facility. LALD-C was identified as the primary LALD but was not available at the time of the survey. LALD-B was present during the survey. LALD-B LALD-B was licensed on November 5, 2021. On February 5, 2024, at 10:55 a.m., the BELTSS website indicated LALD-B was licensed, but was not listed as the Director of Record for any Assisted Living facility. LALD-C LALD-C was licensed on July 30, 2021.	0 110			

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0 110	Continued From page 2 On February 5, 2024, at 10:55 a.m., the BELTSS website indicated LALD-C was licensed, but was not listed as the Director of Record for any Assisted Living facility. On February 5, 2024, at 10:05 a.m., during the entrance conference, LALD-B stated they were not aware of the requirement to identify a facility Director of Record on the BELTSS website. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110			
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, 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).	0 480			

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0 480	Continued From page 3 The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated February 5, 2024, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 580 SS=C	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement and maintain a quality management program (QMP) appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than	0 580			

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0 580	Continued From page 4 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 potential to affect a large portion or all of the residents). The findings include: On February 5, 2024, at 10:00 a.m., during the entrance conference, licensed assisted living director (LALD)-B stated they were not aware of any QMP implemented by the licensee. LALD-B stated they would review licensee documentation for any QMP activities that were possibly discussed. On February 7, 2024, at 1:00 p.m., LALD-B stated licensee had not developed, implemented, or maintained any QMP. LALD-B stated they would need to identify and develop a QMP. The licensee's Quality Improvement policy dated March 28, 2022, indicated the licensee had developed a QMP and would maintain documentation of said QMP. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580			
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	0 680			

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0 680	Continued From page 5 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 provide annual emergency and disaster training to all staff. This had the potential to impact all residents, staff, and visitors to 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 a large portion or all of the residents).	0 680			

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0 680	Continued From page 6 The findings include: On February 5, 2024, at 1:00 p.m., the licensed assisted living director (LALD)-B provided the emergency preparedness plan. The plan lacked documented annual emergency and disaster training. On February 7, 2024, at 2:30 p.m., during the exit conference, LALD-B stated the licensee had not completed any annual emergency and disaster training with any staff. The licensee's Emergency Preparedness policy, dated March 28, 2022, indicated the licensee would complete annual emergency and disaster training as referenced in Appendix Z and Minnesota Rule 4659.0100. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story	0 780			

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0 780	Continued From page 7 within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that functioned and are interconnected so that the actuation of one alarm causes all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On February 6, 2024, at 10:30 a.m., survey staff toured the facility with licensed assisted living director (LALD)-B. Survey staff tested the smoke alarms throughout the home. Upon testing, it was found that the smoke alarms in the facility were	0 780			

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0 780	Continued From page 8 not interconnected and the smoke alarms in the following locations were missing or did not sound when the test button was pressed: 1. Outside bedroom #5 no smoke alarm installed 2. Bedroom #3 no smoke alarm installed 3. Bedroom #4 no smoke alarm installed 4. Outside bedrooms #3 and #4 no smoke alarm installed 5. None of the smoke alarms on the upper level were interconnected with the rest of the facility During interview on February 6, 2024, at 1:30 p.m., LALD-B stated they understood the smoke alarm requirements and would figure out how to get them installed and interconnected. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780			
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by:	0 790			

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0 790	Continued From page 9 Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On February 6, 2024, at 10:30 a.m., survey staff toured the facility with licensed assisted living director (LALD)-B. It was observed that the portable fire extinguishers throughout the facility lacked records to show the required annual certification and monthly visual inspections were performed on the portable fire extinguishers. Documentation is required to demonstrate fire extinguishers have been inspected by facility personnel monthly, and annually replaced with a new extinguisher or serviced annually by a certified technician. It was observed the fire extinguisher was located on the floor and not mounted in accordance with Minnesota Fire Code. MN Fire Code, chapter 7511 indicates fire extinguishers are required to be mounted at least 4 inches off the floor and not higher than 60 inches from the floor to the top of the extinguisher. During interview on February 6, 2024, survey staff explained to LALD-B that the portable fire extinguishers must be provided annual	0 790			

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0 790	Continued From page 10 certification tags and also monthly visual inspection or "quick checks" of each extinguisher by their employees to ensure all portable extinguishers are readily available, fully charged, and operable at their designated location with no obvious physical damage or condition to the extinguisher that would prevent their operation when needed. LALD-B verified the findings and stated they understood the requirements. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790			
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 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. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 800			

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0 800	Continued From page 11 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). Findings include: On February 6, 2024, at 10:30 a.m., survey staff toured the facility with licensed assisted living director (LALD)-B. The following was observed: It was observed that the facility had pest traps located in multiple electrical outlets that were filled with insects. LALD-B stated that the insect infestation used to only be on the first floor, but ever since they installed the new floor in the kitchen/dining room the bugs have been on the second floor too. It was observed that the kitchen/ dining room floor had a one (1) inch tall tripping hazard from the living room to the kitchen as well as from the kitchen to the hallway outside the bedrooms. It was observed that the kitchen and dining room floors were not properly installed and had half (.5) inch to one (1) inch gaps between the floorboards and adjacent to the walls. The finish on the floor surface was also damaged and curling up in places. It was observed that the bathroom floor was damaged adjacent to the bathtub and was cracked from wall to wall running in front of the toilet. Water penetration below the finished floor could damage the subfloor and structure in the area.	0 800			

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0 800	Continued From page 12 It was observed that the pedestal sink was pulled away from the wall leaving a one (1) inch gap where water penetration could get into the wall cavity. The edges around the back of the sink where it had separated were rough and sharp. It was observed outside bedroom #5 that the floorboards in the hallway/ living room were loose and pulled apart by the bedroom door. LALD-B stated the same contractor that installed the kitchen floor also did the hallway and living room areas. It was observed in bedroom #3 that the floor was damaged and the finish was peeling up from the floor material. LALD-B stated she did not know of any event that would have damaged the floor in the bedroom. It was observed in bedroom #4 that the floor was damaged and the finish was peeling up from the floor material. LALD-B also stated she did not know of any event that would have damaged the floor in the bedroom. It was observed on the upper level that the flooring in the kitchen/office work area was incorrectly installed and peeled away from the subfloor. It was observed on the upper level that the kitchen/office work area floor had a two (2) inch tall tripping hazard from the living room to the kitchen/office work area. It was observed on the upper level that bedroom #1 had two locations where the ceiling had been damaged and repaired but still had significant staining in the repaired location. LALD-B stated she did not know what the staining could be.	0 800			

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0 800	Continued From page 13 It was observed on the upper level that the ceiling in the kitchen/office work area was damaged and sagging in two locations. It appeared that someone had attempted a patch and paint solution, but did not address the issue that caused the ceiling to sag. LALD-B stated she did not know what was causing the ceiling to sag and that the damage was there when they moved in. LALD-B visually verified these deficient findings at the time of discovery. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800			
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) 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.	0 810			

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0 810	Continued From page 14 (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 interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During observation on February 6, 2024, at 10:30 a.m., the surveyor observed the fire evacuation diagrams were not posted anywhere in the facility.	0 810			

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0 810	Continued From page 15 On February 6, 2024, licensed assisted living director (LALD)-B provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee's FSEP, titled "Fire Safety", dated March, 28, 2022, failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The provided FSEP was from a third-party provider and had not been updated to the specific facility. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. During an interview on February 8, 2024, at 10:00 a.m., LALD-B stated they had not had an opportunity to update the policy to make it site-specific. The policy reviewed was an	0 810			

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0 810	Continued From page 16 unedited policy purchased from a third-party provider that was not specific to the facility. TRAINING Record review indicated the licensee failed to provide evacuation training to residents at least once per year. LALD-B was unable to provide documentation showing any training offered or training scheduled for a future date for residents on the fire safety and evacuation plan. Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. LALD-B was unable to provide documentation showing any training offered or training scheduled for a future date for employees on the fire safety and evacuation plan. During an interview on February 8, 2024, at 10:00 a.m., LALD-B stated she understood the requirements and would implement a training program that was compliant with statute requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			
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.	0 970			

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0 970	Continued From page 17 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 that waived the licensee's liability for the health, safety, or personal property of a resident. This had the potential to affect 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 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: On February 6, 2024, at 9:20 a.m., licensed assisted living director (LALD)-B provided the licensee's blank assisted living contract and stated the contract was used for all residents who lived at the facility. The licensee's assisted living contract included, under section Indemnification: "[Licensee] shall not be liable for any damage or injury to the resident, or any other person, or to the property, occurring on the premises, or any part thereof, or in common areas thereof, and the resident agrees to hold [licensee] harmless for any claims or damages unless caused solely by negligence of [licensee]." On February 7, 2024, at 2:30 p.m., LALD-B stated the licensee was not aware the contract could not include a waiver of liability. LALD-B	0 970			

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0 970	Continued From page 18 stated they would need to edit the assisted living contract to remove any waiver of liability. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970			
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to:	01060			

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01060	Continued From page 19 (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content for an emergency relocation for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's record lacked documentation of an emergency relocation notification provided by the licensee following hospitalization. R2's diagnoses included schizophrenia, type II diabetes, and depression.	01060			

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01060	Continued From page 20 R2's service plan dated August 9, 2021, indicated R2 received services including assistance with medication administration, dressing and grooming, and behavior management. R2's nursing note dated January 4, 2024, indicated R2 returned from the hospital following dizziness, after seeking care on January 3, 2024. R2's record lacked evidence of a written notice provided to the resident, the residents' legal representative, and designated representative that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident had been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care (OOLTC); - if known and applicable, the approximate date or range of dates within which the resident was expected to return to the facility, or a statement that a return date was not currently known; and - a statement that, if the facility refused to provide housing or services after a relocation, the resident had the right to appeal and the contact information for the agency to which the resident may submit an appeal. On February 6, 2024, at 11:30 a.m., licensed assisted living director (LALD)-B stated a written notice had not been provided with the required content. In addition, LALD-B stated he was not aware of the requirement to provide a relocation notice to R2 or their representative. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060			

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01500	Continued From page 21	01500			
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss.	01500			

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NAME OF PROVIDER OR SUPPLIER KUBRA HOME CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2437 15TH AVENUE SOUTH MINNEAPOLIS, MN 55404		
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01500	Continued From page 22 Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure annual training was provided and included all required topics for each 12 months of employment, for two of two employees (unlicensed personnel (ULP)-A and licensed assisted living director (LALD)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	01500			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33123	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/07/2024
NAME OF PROVIDER OR SUPPLIER KUBRA HOME CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2437 15TH AVENUE SOUTH 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
01500	Continued From page 23 ULP-A and LALD-B were hired May 12, 2020, and March 23, 2018, respectively. On August 1, 2021, the licensee converted their 144A Home Care license to the current 144G Assisted Living license. ULP-A and LALD-B's employee records both lacked evidence of annual training provided since either employee was hired. On February 7, 2024, at 1:00 p.m., LALD-B stated the licensee had not provided annual training as required to any employee. LALD-B stated the licensee had provided annual training related to medication management, but licensee was not aware of the required topics to be covered for employee annual training. The licensee's Personnel Records policy dated March 28, 2022, indicated the licensee would provide and document all required annual training in each employee's records. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500			

Type: Full
Date: 02/05/24
Time: 12:40:45
Report: 1029241030

Food and Beverage Establishment Inspection Report

Page 1

Location:

Kubra Home Care Inc
2437 15th Avenue South
Minneapolis, MN55404
Hennepin County, 27

Establishment Info:

ID #: 0039418
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 6122320907
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.

2-200 Employee Health

2-201.11C

**** Priority 1 ****

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.

NO EMPLOYEE ILLNESS LOG. ILLNESS LOG OBTAINED FROM MDH SITE AND PRINTED DURING INSPECTION. ILLNESS PROCEDURES DISCUSSED.

Comply By: 02/05/24

4-300 Equipment Numbers and Capacities

4-301.12A

**** Priority 2 ****

MN Rule 4626.0680A Provide a 3 compartment sink with integrally attached drainboards at each end for manually washing, rinsing and sanitizing equipment and utensils.

2 COMPARTMENT SINK (ONE COMPARTMENT OF WHICH IS DESIGNATED AS HANDWASHING) USED TO WASH/RINSE/SANITIZE. INSTRUCTED REPRESENTATIVE TO USE 3-COMP SINK OR NSF/ANSI 184 DISHWASHER.

Comply By: 02/16/24

4-300 Equipment Numbers and Capacities

4-302.14

**** Priority 2 ****

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

NO CHLORINE TEST STRIPS TO TEST SANITIZER. INSTRUCTED REPRESENTATIVE TO OBTAIN AND USE TEST STRIPS.

Comply By: 02/05/24

Type: Full
Date: 02/05/24
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Kubra Home Care Inc

Food and Beverage Establishment Inspection Report

Page 2

6-300 Physical Facility Numbers and Capacities

6-301.12 **** Priority 2 ****

MN Rule 4626.1445 Provide and maintain a supply of individual disposable towels, a continuous towel system, a heated-air hand drying device, or an approved ambient air temperature hand drying device at each handwashing sink or group of adjacent handwashing sinks.

PAPER TOWELS NOT AT HANDWASHING SINK. INSTRUCTED REPRESENTATIVE TO MOVE AND MAINTAIN PAPER TOWELS AT HANDWASHING SINK.

Comply By: 02/05/24

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.

INSTRUCTED ESTABLISHMENT TO ELIMINATE COCKROACHES BY MEANS OF PEST CONTROL. ESTABLISHMENT INDICATED THEY EMPLOY A PROFESSIONAL PEST COMPANY. INTEGRATED PEST MANAGEMENT WAS DISCUSSED.

Comply By: 02/16/24

4-200 Equipment Design and Construction

4-204.112A

MN Rule 4626.0620A Provide a temperature measuring device located in the warmest part of mechanically refrigerated units and coolest part of hot food storage units that are capable of measuring air temperature or a simulated product temperature.

NO INTERNAL THERMOMETER IN REFRIGERATOR. INSTRUCTED REPRESENTATIVE TO PROVIDE INTERNAL THERMOMETER.

Comply By: 02/09/24

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

LONG PIECE OF METAL ON OVEN DOOR, INTENDED TO BE FLUSH WITH DOOR, JUTTING OUT AT ~ 40° ANGLE. INSTRUCTED REPRESENTATIVE TO REPAIR OR REPLACE.

Comply By: 02/16/24

6-200 Physical Facility Design and Construction

6-202.14

MN Rule 4626.1390 Provide necessary walls and ceiling to completely enclose toilet rooms and a tight-fitting, self-closing device on the toilet room door.

BATHROOM DOOR OPEN AND NOT SELF CLOSING. INSTRUCTED REPRESENTATIVE TO CLOSE DOOR AND TO HAVE IT BE SELF CLOSING.

Comply By: 02/09/24

Type: Full
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Kubra Home Care Inc

Food and Beverage Establishment Inspection Report

Page 3

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.

KITCHEN AREA IN DISREPAIR. SEE COMMENTS. INSTRUCTED REPRESENTATIVE TO BRING KITCHEN INTO GOOD REPAIR.

Comply By: 02/16/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.111ABD

MN Rule 4626.1565ABD Provide control of insects, rodents, and other pests by routinely inspecting incoming food and supply shipments; routinely inspecting the premises for evidence of pests; and eliminating harborage conditions.

IMMENSE QUANTITY OF LIVE AND DEAD COCKROACHES IN KITCHEN. INSTRUCTED REPRESENTATIVE TO ELIMINATE THE ABUNDANCE OF HARBORAGE CONDITIONS PROVIDED BY THE GAPS, CRACKS, HOLES, AND CAVITIES IN THE KITCHEN AREA.

Comply By: 02/16/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.112

MN Rule 4626.1570 Remove dead or trapped birds, insects, rodents, and other pests from the premises.

ABUNDANCE OF COCKROACH CORPSES IN KITCHEN AREA. INSTRUCTED REPRESENTATIVE TO REMOVE, CLEAN, AND MAINTAIN CLEAN.

Comply By: 02/05/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.114AB

MN Rule 4626.1580AB Remove all items unnecessary to the operation or maintenance of the establishment and litter from the premises.

UNUSED SMALL REFRIGERATOR PRESENT. MOLD AND COCKROACH CORPSES IN INTERIOR. INSTRUCTED REPRESENTATIVE TO REMOVE.

Comply By: 02/09/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

MN Rule 4626.1520A Clean and maintain all physical facilities clean.

FOOD RESIDUES AND GREASE ON MULTIPLE SURFACES. INSTRUCTED REPRESENTATIVE TO CLEAN AND MAINTAIN CLEAN.

Comply By: 02/05/24

Type: Full
Date: 02/05/24
Time: 12:40:45
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Kubra Home Care Inc

Food and Beverage Establishment
Inspection Report

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.16

MN Rule 4626.1540 Hang mops to dry after each use and do not store mops in a manner that will soil walls, equipment or supplies.

MOP NOT HUNG TO AIR DRY. INSTRUCTED REPRESENTATIVE TO HANG MOPS TO AIR DRY.

Comply By: 02/05/24

Food and Equipment Temperatures

Process/Item: MILK
Temperature: 39 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

Process/Item: SLICED HAM
Temperature: 39 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

Total Orders	In This Report	Priority 1	Priority 2	Priority 3
		1	4	9

INSPECTION CONDUCTED WITH MUNA JAMA, HOUSE MANAGER AND CFPM. IDENTIFIED ISSUES DISCUSSED WITH MUNA THROUGHOUT AND AFTER THE INSPECTION.

- SOME OF THE TOPICS DISCUSSED INCLUDED:
- EMPLOYEE ILLNESS REPORTING AND EXCLUSION PROCEDURES
 - HYGIENIC PRACTICES AND THE IMPORTANCE OF ADEQUATE HANDWASHING
 - ASPECTS OF INTEGRATED PEST MANAGEMENT
 - HIGHLY SUSCEPTIBLE POPULATIONS
 - RECEIVING AND HOLDING TEMPERATURES
 - SANITIZING BY HEAT AND/OR CHEMICAL

KITCHEN AREA RESIDENTIAL IN NATURE WITH FAUX-WOOD LAMINATE FLOORING, POPCORN CEILING, PAINTED WALLS, MDF COUNTERTOPS COVERED IN LAMINATE, WOOD/COMPOSITE WOOD CABINETRY AND DRAWERS. KITCHEN AREA IS IN POOR CONDITION AND REQUIRES MAINTENANCE: HOLES IN WALLS; MISSING/CHIPPING PAINT; GAPS, CRACKS, AND MISSING FLOORING; EXPOSED MDF; AND CRACKED BROKEN CABINETRY WITH SOME OF THE CABINET DOORS FALLING OFF OR ON FLOOR. DISREPAIR OF KITCHEN AREA APPEARS TO BE PROVIDING ACCESS POINTS AND HARBORAGE AREAS FOR PESTS.

PRODIGIOUS AMOUNTS OF LIVE AND DEAD COCKROACHES OBSERVED. COCKROACHES APPEARED TO BE THE GERMAN COCKROACH (BLATTELLA GERMANICA). NECESSITY OF ELIMINATION OF THE B. GERMANICA INFESTATION WAS DISCUSSED GIVEN THEIR ABILITY TO HARBOR AND SPREAD FOODBORNE ILLNESS PATHOGENS: SALMONELLA, ESCHERICHIA COLI, BACILLUS CEREUS, SHIGELLA, ROTAVIRUS, ASPERGILLUS FUMIGATUS, CRYPTOSPORIDIUM PARVUM, AND STAPHYLOCOCCUS AUREUS.

Type: Full
Date: 02/05/24
Time: 12:40:45
Report: 1029241030
Kubra Home Care Inc

Food and Beverage Establishment Inspection Report

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IDENTIFIED ISSUES EXPRESSED TO ANGEL WOEHLE, RN, PHN, MSN, LALD, CADDCT,
NURSE EVALUATOR, FOLLOWING THE 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 1029241030 of 02/05/24.

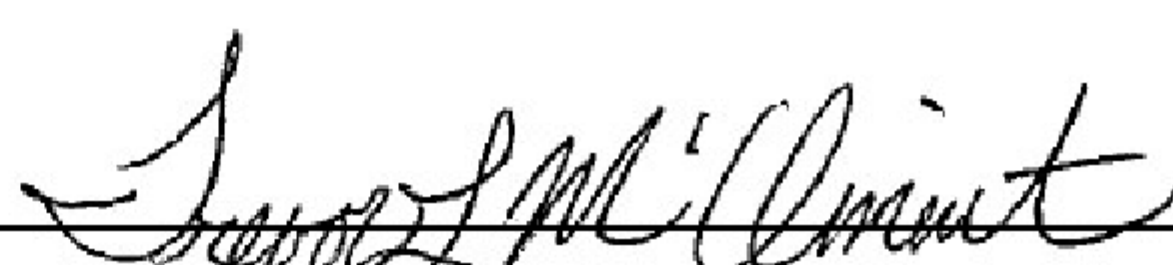
Certified Food Protection Manager: MUNA ABDI JAMA

Certification Number: FM119238 Expires: 09/12/26

Inspection report reviewed with person in charge and emailed.

Signed: _____

MUNA JAMA
HOUSE MANAGER

Signed:  _____

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

Report #: 1029241030

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

02/05/24

No. of Repeat RF/PHI Categories Out

0

Time In

12:40:45

Legal Authority MN Rules Chapter 4626

Time Out

Kubra Home Care Inc

Address

2437 15th Avenue South

City/State

Minneapolis, MN

Zip Code

55404

Telephone

6122320907

License/Permit #

0039418

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 Hygienic 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

X

Thermometers provided & accurate

Food Identification

37

Food properly labeled; 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

Compliance Status

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

X

Food & non-food contact surfaces cleanable, properly designed, constructed, & used

48

X

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

X

Toilet facilities: properly constructed, supplied, & cleaned

54

Garbage & refuse properly disposed; facilities maintained

55

X

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)

Date:

02/06/24

Inspector (Signature)