Electronically Delivered

April 17, 2025

Licensee
Midwest Homes Inc.
2445 10th Avenue South
Minneapolis, MN 55404

RE: Project Number(s) SL35007016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 18, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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 . . ."

IMPOSITION OF FINES

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

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

§ 144G.20.

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

0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00
0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - $500.00

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.

The correction order documentation should include the following:

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

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

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

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

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

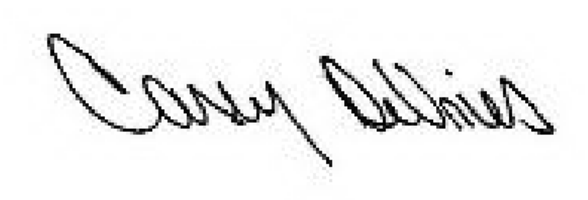
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35007	A. BUILDING: _____ B. WING _____	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST HOMES INC	2445 10TH 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(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: SL35007016 -0 On March 17, 2025, through March 18, 2025, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were four residents, all of them received services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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 issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 345 SS=C	144G.30 Subd. 5. (c)(2), (d) Correction orders (c)(2) make available, in a manner readily accessible to residents and others, including	0 345		

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0 345	Continued From page 1 provision of a paper copy upon request, the most recent plan of correction documenting the actions taken by the facility to comply with the correction order. (d) After the plan of correction is made available under paragraph (c), clause (2), the facility must provide a copy of the facility's most recent plan of correction to any individual who requests it. A copy of the most recent plan of correction must be provided within 30 days after the request and in a format determined by the facility, except the facility must make reasonable accommodations in providing the plan of correction in another format, including a paper copy, upon request. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to make available the most recent plan of correction in a manner readily accessible to residents and others, including provision of a paper copy upon request, documenting the actions taken by the facility to comply with the correction orders, after a survey conducted on October 17 through October 19, 2022. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). On March 18, 2025, at 1:50 p.m., licensed assisted living director (LALD)-D stated they did not have plan of correction to document the actions taken by the facility to comply with the correction orders.	0 345		

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0 345	Continued From page 2 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 345		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage;	0 480		

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0 480	Continued From page 3 (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include:	0 480		

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0 480	Continued From page 4 Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated March 17, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 630 SS=F	144G.42 Subd. 6 (b) 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. 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 (IAPP) was developed to include the required content for one of three residents (R3). 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	0 630		

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0 630	Continued From page 5 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: R3 was admitted to the licensee on December 14, 2021, and discharged to the licensee's sister facility on May 1, 2024. R3 was readmitted to the licensee on March 16, 2025. R3's diagnoses included major depressive disorder, scoliosis, post-traumatic stress disorder, major anxiety, suicidal ideation, mild intellectual disability, borderline personality disorder, and cognitive deficits. On March 17, 2025, at 12:23 p.m., the surveyor observed ULP-A administer oral medication to R3. R3's record included an IAPP and Service Plan completed on December 14, 2024, while R3 was residing at the licensee's sister facility. However, the licensee's current address was listed on R3's IAPP and Service Plan as R3's location of residence. On March 18, 2025, at 2:15 p.m., licensed assisted living director (LALD)-D stated they did not do any paperwork (including assisted living contract) for R3's discharge or readmission as R3 got transferred within the same company. On March 18, 2025, at 2:44 p.m., clinical nurse supervisor (CNS)-C stated they did not do any paperwork including admission assessment, service plan, individual abuse prevention plan, individual medication management plan,	0 630		

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0 630	Continued From page 6 discharge summary, medication disposition, or individual treatment and therapy plan for R3 when R3 got readmitted to the licensee. CNS-C stated they transferred R3's physical chart to the licensee's sister facility upon discharge and they got the physical chart back from the sister facility upon readmission. CNS-C stated they were not aware of the requirement to do the above-mentioned paperwork when a resident moved to a different facility under the same ownership. On March 18, 2025, at 3:00 p.m., CNS-C stated they completed the IAPP and the Service Plan dated December 14, 2024, when R3 resided at the licensee's sister facility, but they forgot to change the address on the IAPP and the Service Plan. The licensee's undated Abuse Prevention Plan Policy indicated all clients (residents) admitted to the agency will be assessed for their susceptibility to abuse by other individuals, including other vulnerable adults and their risk of abusing other vulnerable adults. The agency will develop a statement of the specific measures that will be taken to minimize the risk of abuse to that person and other vulnerable adults, including self-abuse. The plan will be incorporated into the client care plan and will reflect the client's ability to participate in and direct their own care or the presence of an identified caregiver. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		

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0 650	Continued From page 7	0 650		
0 650 SS=E	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records included all required content for two of three employees (unlicensed personnel (ULP)-A, ULP-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number	0 650		

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0 650	Continued From page 8 of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-A ULP-A was hired on August 1, 2023, to provide direct care services to residents. ULP-A's employee record included Yearly Annual Performance Report Form dated December 28, 2023. The form was signed by ULP-A, however the form was not completed and not signed by the reviewer. ULP-B ULP-B was hired on December 7, 2023, to provide direct care services to residents. ULP-B's employee record did not include a Yearly Annual Performance Report Form. On March 18, 2025, at 11:10 a.m., licensed assisted living director (LALD)-D stated the program manager, lead worker, or the LALD themselves did the annual performance reviews every year. LALD-D stated the previous program manager started the performance review for ULP-A but forgot to complete it. LALD-D stated they did not know how ULP-B's performance review was missed. The licensee's 4.05 Employee Records Policy dated August 1, 2021, indicated employee records for each employee will include documentation of annual performance reviews identifying areas of improvement needed and training needs.	0 650		

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0 650	Continued From page 9 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
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 by: Based on interview and record review, the licensee failed to maintain a written emergency	0 680		

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0 680	Continued From page 10 preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a 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 emergency preparedness plan dated March 28, 2022, lacked evidence of the following required content: - documentation of risk assessment; - procedures for tracking of staff and patients; - policies and procedures for volunteers; - role under a waiver declared by secretary; - sharing information on occupancy/needs; - long term care family notification; - annual review of the EPP; and - quarterly review of missing resident policy. On March 17, 2025, at 1:40 p.m., licensed assisted living director (LALD)-D stated the EPP, and the missing resident plan, was reviewed every six months. LALD-D also stated they did not know why the review dates for missing resident and for the EPP was not documented. LALD-D stated they were not aware the EPP plan was missing the above listed items, and they did not know why the items listed above were missing from the plan. The licensee's Emergency Preparedness Plan	0 680		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 680	Continued From page 11 policy dated August 1, 2021, indicated it is the intent that the licensee has in place an effective and compliant Emergency Preparedness Plan. The intent is the plan will be aligned with the Centers for Medicare and Medicaid Services State Operation Manual Appendix Z: "State Operations Manual Appendix Z - Emergency Preparedness for All Provides and Certified Supplier Types: Interpretive Guidance." The licensee's undated Client at Risk of Wandering and/or Elopement policy did not indicate a timeline as to how often the plan should be reviewed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any;	0 730		

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	35007	A. BUILDING: _____ B. WING _____	03/18/2025

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0 730	Continued From page 12 (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a discharge summary with required content for one of one resident (R3) discharged from the licensee. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 730		

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0 730	Continued From page 13 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: R3 was admitted to the licensee on December 14, 2021, and discharged to the licensee's sister facility on May 1, 2024. R3 was readmitted to the licensee on March 16, 2025. R3's diagnoses included major depressive disorder, scoliosis, post-traumatic stress disorder, major anxiety, suicidal ideation, mild intellectual disability, borderline personality disorder, and cognitive deficits. On March 17, 2025, at12:23 p.m., the surveyor observed ULP-A administer oral medication to R3. R3's recorded lacked a discharge summary to include the following required information: - a summary of the resident's stay that included diagnoses, courses of illnesses, allergies, treatments and therapies, and pertinent lab, radiology, and consultation results; - a final summary of the resident's status from the latest assessment or review under Minnesota Statutes, section 144G.70, if applicable, that includes the resident status, including baseline and current mental, behavioral, and functional status; - a reconciliation of all predischarge medications with the resident's post discharge prescribed and over-the-counter medications; and - a post discharge plan that is developed with the	0 730		

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0 730	Continued From page 14 resident and, with the resident's consent, the resident's representatives, which will help the resident adjust to a new living environment. The post discharge plan must indicate where the resident plans to reside, any arrangements that have been made for the resident's follow-up care, and any post discharge medical and nonmedical services the resident will need. On March 18, 2025, at 2:15 p.m., licensed assisted living director (LALD)-D stated they did not do any paperwork for R3's discharge or readmission as R3 got transferred within the same company. On March 18, 2025, at 2:44 p.m., clinical nurse supervisor (CNS)-C stated they did not do any paperwork including admission assessment, service plan, individual abuse prevention plan, individual medication management plan, discharge summary, medication disposition, or individual treatment and therapy plan for R3 when R3 got readmitted to the licensee. CNS-C stated they transferred R3's physical chart to the licensee's sister facility upon discharge and they got the physical chart back from the sister facility upon readmission. CNS-C stated they were not aware of the requirement to do the above-mentioned paperwork when a resident moved to a different facility under the same ownership. The Licensee's undated Resident Discharge Process policy read, "DISCHARGE SUMMARY 1. A discharge summary will be prepared at the time of discharge. 2. The facility will provide the resident/representative with a written discharge summary at time of discharge. 3. Copies of the discharge summary will be	0 730		

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0 730	Continued From page 15 provided to other disciplines as required or as approved by the resident. 4. The discharge summary will include: a. Diagnoses b. Courses of illness c. Allergies d. Treatments/therapies e. Pertinent lab results f. Pertinent X-ray results g. Pertinent consultation results h. Summary of resident status based on latest assessment i. Resident status at baseline or when admitted ii. Current mental, behavioral and functional status i. Reconciliation of all predischarge medications with post discharge prescribed and over the counter medications j. Post discharge plan developed with the resident and with consent the resident's representatives k. The plan will include: i. Planned residence ii. Arrangements with follow-up care iii. Needed medical and non-medical services after discharge 5. The discharge summary may be developed by the RN, Assisted Living Director or designee appropriate to information required in the discharge summary based on the resident and the services they received during the facility stay. 6. A copy of the discharge summary is filed in the resident record." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		

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0 775	Continued From page 16	0 775		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the current State Fire Code in Minnesota Rules, chapter 7511. 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, but was not likely to cause serious injury, impairment, or death), and 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 a facility tour on March 18, 2025, from 1:00 p.m. to 3:30 p.m., with licensed assisted living director (LALD)-D., The surveyor made the following observations of non-compliance with current Minnesota Fire Code provisions. EXTENSION CORD: In resident room 3, the closet was being used as the facility laundry room. There was an extension cord being used as a continuous power source for the washer. Extension cords should not be used as a permanent source of power.	0 775		

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0 775	Continued From page 17 CARBON MONOXIDE ALARMS: There was no carbon monoxide alarm outside of bedroom 4. Carbon monoxide alarms should be within 10' on the outside of the sleeping room. SMOKE ALARM: Battery smoke alarm in bedroom 4 had paint on the face of the alarm and alarm was over 10 years past the manufacturer date. Smoke alarms should not have paint on them which could affect operation and performance. Single- and multiple-station smoke alarms shall be replaced when: 1. They fail to respond to operability tests. 2. They exceed ten years from the date of manufacture. Smoke alarms shall be replaced with smoke alarms having the same type of power supply. During a facility tour on March 18, 2025, at 2:00 p.m., LALD-D verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) days	0 775		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment 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 within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics;	0 780		

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0 780	Continued From page 18 (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 inside all levels of the facility and that were interconnected so that the actuation of one alarm caused all alarms in the dwelling unit to actuate. 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, 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 a facility tour on March 18, 2025, from 1:00 p.m. to 3:30 p.m., with licensed assisted living director (LALD)-D. Surveyor observed hard-wired smoke alarm missing from the basement level	0 780		

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0 780	Continued From page 19 hallway outside of bedroom 4. Alarms are required on each story of the facility including basements. INTERCONNECTED: Alarm in bedroom 4 was battery powered and not interconnected with hard-wired alarms throughout the facility. Smoke alarms were not interconnected so activation of one alarm activates all alarms throughout the facility During a facility tour on March 18, 2025, at 2:00 p.m., LALD-D, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) days	0 780		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be	0 810		

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0 810	Continued From page 20 readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training 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: On a facility tour on March 18, 2025, from 1:00 p.m. to 3:30 p.m., with licensed assisted living director (LALD)-D. Surveyor observed the posted evacuation plans lacked identification of resident rooms. Exit plan diagrams must correctly show	0 810		

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0 810	Continued From page 21 facility layout to reduce confusion and potential obstructions for egress in a fire or similar emergency. On March 18, 2025, licensed assisted living director (LALD)-D 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 Policy", 2/1/2022, failed to include the following: STAFF ACTIONS: 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 plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but the plan was designed for a building with life safety systems such as fire doors and smoke compartments. RESIDENT ACTIONS: The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. On March 18, 2025, at 2:00 p.m., LALD-D stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. The policy reviewed was an unedited policy purchased from a third-party provider that was not specific to the facility. UNIQUE AND UNUSUAL RESIDENT NEEDS:	0 810		

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0 810	Continued From page 22 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. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. LALD-D lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. The licensee failed to provide training to employees on the FSEP at least twice per year. LALD-D was unable to provide any yearly training documents during the survey. LALD-D stated that staff was trained during drills. No other training documentation was provided. On March 18, 2025, at 2:00 p.m., LALD-D stated they understood the requirements for training residents and staff and would implement a training program that was compliant with statute requirements. DRILLS: The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Record review of licensee's evacuation drill logs, showed drills conducted on 1/30/24, 3/20/24, 5/25/24, 7/02/24 and 10/7/24. Drills documentation was handwritten and was only	0 810		

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0 810	Continued From page 23 performed during the day shifts. No other documentation was provided. On March 18, 2025, at 2:00 p.m., LALD-D stated there were no additional documented drills for the facility and would document fire drills that are compliant with statute requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 900 SS=F	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3.	0 900		

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0 900	Continued From page 24 (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to develop and execute a written assisted living contract with the required content for one of three residents (R3). 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: R3 was admitted to the licensee on December 14, 2021, and discharged to the licensee's sister facility on May 1, 2024. R3 was readmitted to the licensee on March 16, 2025. R3's diagnoses included major depressive disorder, scoliosis, post-traumatic stress disorder, major anxiety, suicidal ideation, mild intellectual disability, borderline personality disorder, and cognitive deficits. On March 17, 2025, at12:23 p.m., the surveyor observed ULP-A administer oral medication to R3.	0 900		

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0 900	Continued From page 25 R3's record included an assisted living contract form entitled Resident Contract for Assisted Living completed on December 14, 2023. R3's record also included another Resident Contract for Assisted Living completed on November 25, 2024, for the licensee's sister facility. R3's record lacked a new written contract with licensee's facility address, which included all of the terms concerning the provisions of the following as required: - housing; - assisted living services, whether provided directly by the licensee or by management agreement or other agreement; and - the resident's service plan, if applicable. In addition, R3's records lacked evidence that the contract had been fully executed as the licensee must: - offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; - give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed; and - the licensee must offer the resident the opportunity to identify a designated representative. On March 18, 2025, at 2:15 p.m., licensed assisted living director (LALD)-D stated they did not do any paperwork (including an assisted living contract) for R3's discharge or readmission as R3 got transferred within the same company. On March 18, 2025, at 2:44 p.m., clinical nurse supervisor (CNS)-C stated they did not do any	0 900		

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	35007	A. BUILDING: _____ B. WING _____	03/18/2025

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0 900	Continued From page 26 paperwork including admission assessment, service plan, individual abuse prevention plan, individual medication management plan, discharge summary, medication disposition, or individual treatment and therapy plan for R3 when R3 got readmitted to the licensee. CNS-C stated they transferred R3's physical chart to the licensee's sister facility upon discharge and they got the physical chart back from the sister facility upon readmission. CNS-C stated they were not aware of the requirement to do the above-mentioned paperwork when a resident moved to a different facility under the same ownership. The Licensee's 1.05 signing Assisted Living Contract Policy dated August 1, 2021, indicated when a prospective resident decides to move into the licensee's facility, Assisted Living contract will be signed and received by the facility. The policy read, "PROCEDURE: When a prospective resident is ready to sign a lease and move in: 1. Fill in all the blanks of the contract and provide the prospective resident and/or responsible person a copy of the appropriate assisted living contract. 2. Emphasize to the prospective resident and/or responsible person that the assisted living contract is a legal, binding contract. 3. Review the assisted living contract with the prospective resident and/or responsible person and answer any questions they may have. 4. Sign two copies of the contract 5. Give one copy to the prospective resident and/or responsible person and retain one copy for the resident record. 6. Collect any monies due as a result of signing the contract."	0 900		

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0 900	Continued From page 27 7. Make two photocopies of any check, date and sign the photocopies. Give one copy to the resident and/or responsible person as a receipt. Retain the other for the resident record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 900		
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for one of one resident (R1). 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	0 910		

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0 910	Continued From page 28 residents). The findings include: R1 was admitted to the licensee on January 8, 2024, and received assisted living services. R1's Assisted Living Contract signed on January 8, 2024, lacked the following required content: - in a conspicuous place and manner on the contract the legal name and health facility identification number (HFID#) of the licensee. On March 17, 2025, at 12:50 p.m., licensed assisted living director (LALD)-D stated they used the same form for all residents and stated they were not aware they needed to include the licensee's HFID number on the assisted living contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910		
01500 SS=D	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;	01500		

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01500	Continued From page 29 (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. 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	01500		

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01500	Continued From page 30 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 employees received at least eight hours of annual training for each 12 months of employment for one of three employees (unlicensed personnel (ULP)-A). 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: ULP-A was hired on August 1, 2023, to provide direct care to residents. ULP-A's employee record included the following annual training: - assisted Living Bill of Rights completed on February 1, 2025; and - effective approaches to use to problems solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders completed on February 15, 2025. ULP-A's employee record lacked the following	01500		

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01500	Continued From page 31 annual training topics completed within the last 12 months: - reporting maltreatment of vulnerable adults or minors, last completed on September 16, 2023; - infection control techniques- principles of person-centered planning and service delivery, last completed on September 16, 2023; - review of provider's policies and procedures (not completed); and - principles of person-centered planning/service delivery, last completed on September 5, 2023. On March 28, 2025, at 11:03 a.m., licensed assisted living director (LALD)-D stated they forgot to assign the remainder of ULP-A's dementia and annual trainings. The licensee's 5.06 Annual Required Staff Training policy dated August 1, 2021, indicated all staff providing assisted living services will complete at least eight hours of training for each 12 months of employment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of	01530		

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01530	Continued From page 32 employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure three of three employees (unlicensed personnel (ULP)-A, ULP-B, ULP-E) received at least eight hours of initial dementia care training within 160 working hours of their employment start date, and two hours of dementia training annually. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	01530		

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01530	Continued From page 33 ULP-A ULP-A was hired on August 1, 2023, to provide direct care services to residents. ULP-A's employee record included an Educare (online training platform) training document which indicated ULP-A had 5 hours of dementia training completed on September 16, 2023, and 3 hours of dementia training completed on February 1 through February 15, 2025, for a total of 8 hours, which was 3 hours short of the required eight hours of dementia training required to be completed within 160 working hours of the ULP's employment start date. ULP-B ULP-B was hired on December 7, 2023, to provide direct care services to residents. ULP-B's employee record included an Educare training document which indicated ULP-B had 5 hours of dementia training completed on January 2, 2024, through March 16, 2024, for a total of 5 hours, which was 3 hours short of the required eight hours of dementia training required to be completed within 160 working hours of the ULP's employment start date. ULP-E ULP-E was hired on February 10, 2024, to provide direct care services to residents. ULP-E's employee record included an Educare training document which indicated ULP-E had 5 hours of dementia training completed on March 18, 2024, through March 20, 2024, and 2.5 hours of dementia training completed on February 24, 2025, for a total of 7.5 hours, which was 0.5 hours short of the required eight hours of	01530		

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01530	Continued From page 34 dementia training required to be completed within 160 working hours of the ULP's employment start date. On March 18, 2025, at 10:20 a.m., clinical nurse supervisor (CNS)-C stated they were aware of the required 8 hours of initial dementia training and 2 hours of annual dementia trainings to be given every year. CNS-C stated they had not been looking at the hours closely and stated they would pay close attention to the hours going forward. On March 18, 2025, at 10:34 a.m., CNS-C stated ULP-A had worked for the licensee for more than 160 hours. On March 18, 2025, at 12:20 p.m., licensed assisted living director (LALD)-D stated ULP-B worked 16 hours a week and had worked for the licensee for more than 160 hours. LALD-D stated ULP-E worked 40 hours a week and had worked for the licensee for more than 160 hours. The licensee's 5.03 Dementia Training policy dated August 1, 2021, indicated direct care employees will complete eight (8) hours of initial training within 160 hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must	01620		

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01620	Continued From page 35 be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident assessment and reassessment, not to exceed 90 calendar days from the last date of the assessment for one of three residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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	01620		

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01620	Continued From page 36 only occasionally). The findings include: R1 was admitted to the licensee on January 8, 2024, and began receiving assisted living services. R1's diagnoses included bipolar disorder, unspecified psychosis, anxiety disorder, and mild intellectual disability. R1's Service Plan signed and dated January 8, 2025, indicated R1 received assistance with medication administration, bathing, grooming, dressing, manage behavior, and manage symptoms. R1's record included an admission assessment completed on January 8, 2024, 14-day nursing assessment completed on January 8, 2024 [sic], and 90-day nursing assessments completed on March 6, 2024, June 24, 2024, and September 22, 2024. R1's record lacked a 90-day assessment which was due on December 21, 2024. In addition, R1's 90-day nursing assessment completed on June 24, 2024, was late by 20 days. On March 17, 2024, at 1:36 p.m., clinical nurse supervisor (CNS)-C stated they usually checked the calendar to find the assessment due dates and stated it was an oversight on their part. The licensee's 6.01 Assessment Reviews and Monitoring policy dated August 1, 2021, indicated resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident	01620		

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01620	Continued From page 37 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. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01630 SS=F	144G.70 Subd. 3 Temporary service plan When a facility initiates services and the individualized assessment required in subdivision 2 has not been completed, the facility must complete a temporary plan and agreement with the resident for services. A temporary service plan shall not be effective for more than 72 hours. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to initiate a temporary service plan for one of three residents (R3). 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: R3 was admitted to the licensee on December 14, 2021, and discharged to the licensee's sister	01630		

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01630	Continued From page 38 facility on May 1, 2024. R3 was readmitted to the licensee on March 16, 2025. R3's diagnoses included major depressive disorder, scoliosis, post-traumatic stress disorder, major anxiety, suicidal ideation, mild intellectual disability, borderline personality disorder, and cognitive deficits. On March 17, 2025, at12:23 p.m., the surveyor observed ULP-A administer oral medication to R3. R3's record included an individual abuse prevention plan (IAPP) and Service Plan completed on December 14, 2024, while R3 resided at the licensee's sister facility. However, the licensee's current address was listed on R3's IAPP and Service Plan as R3's location of residence. R3's record lacked evidence a temporary service plan (not to exceed 72 hours) was completed with the resident at the time services were initiated by the facility (licensee) as required. On March 18, 2025, at 2:15 p.m., licensed assisted living director (LALD)-D stated they did not do any paperwork (including an assisted living contract) for R3's discharge or readmission as R3 got transferred within the same company. On March 18, 2025, at 2:44 p.m., clinical nurse supervisor (CNS)-C stated they did not do any paperwork including admission assessment, service plan, individual abuse prevention plan, individual medication management plan, discharge summary, medication disposition, or individual treatment and therapy plan for R3 when R3 got readmitted to the licensee. CNS-C stated	01630		

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01630	Continued From page 39 they transferred R3's physical chart to the licensee's sister facility upon discharge and they got the physical chart back from the sister facility upon readmission. CNS-C stated they were not aware of the requirement to do the above-mentioned paperwork when a resident moved to a different facility under the same ownership. On March 18, 2025, at 3:00 p.m., CNS-C stated they completed the IAPP and the Service Plan dated December 14, 2024, when R3 resided at the licensee's sister facility, but they forgot to change the address on the IAPP and the Service Plan. The licensee's 6.07 Service Plan-Temporary dated August 1, 2021, indicated if the licensee initiates services prior to an individualized assessment having been completed, the licensee will create a temporary service plan and agreement with the resident for services. A temporary service plan will not be utilized for more than 72 hours. An individualized assessment will be completed prior to the expiration of the temporary service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01630		
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	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35007	A. BUILDING: _____ B. WING _____	03/18/2025

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01730	Continued From page 40 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. (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	01730		

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01730	Continued From page 41 review, the licensee failed to develop and maintain a current individualized medication management record for each resident to include all required content for one of three residents (R3). 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: R3 was admitted to the licensee on December 14, 2021, and discharged to the licensee's sister facility on May 1, 2024. R3 was readmitted to the licensee on March 16, 2025. R3's diagnoses included major depressive disorder, scoliosis, post-traumatic stress disorder, major anxiety, suicidal ideation, mild intellectual disability, borderline personality disorder, and cognitive deficits. On March 17, 2025, at 12:23 p.m., the surveyor observed ULP-A administer oral medication to R3. R3's record contained Service Plan and Client Medication Plan dated December 14, 2024, which was completed while R3 was resident at the licensee's sister facility. R3's record lacked an individualized medication management plan following R3's readmission to	01730		

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01730	Continued From page 42 the licensee. On March 18, 2025, at 2:15 p.m., licensed assisted living director (LALD)-D stated they did not do any paperwork (including assisted living contract) for R3's discharge or readmission as R3 got transferred within the same company. On March 18, 2025, at 2:44 p.m., clinical nurse supervisor (CNS)-C stated they did not do any paperwork including admission assessment, service plan, individual abuse prevention plan, individual medication management plan, discharge summary, medication disposition, and individual treatment and therapy plan for R3 when R3 got readmitted to the licensee. CNS-C stated they transferred R3's physical chart to the licensee's sister facility upon discharge and they got the physical chart back from the sister facility upon readmission. CNS-C stated they were not aware of the requirement to do the above-mentioned paperwork when a resident moved to a different facility under the same ownership. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date	01760		

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01760	Continued From page 43 and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document medication administration for one of three residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted to the licensee on January 8, 2024, and began receiving assisted living services. R1's diagnoses included bipolar disorder, unspecified psychosis, anxiety disorder, and mild intellectual disability. R1's Service Plan signed and dated January 8, 2025, indicated R1 received assistance with medication administration, bathing, grooming, dressing, manage behavior, and manage symptoms.	01760		

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01760	Continued From page 44 R1's medication administration record (MAR) for the month of March 2025, indicated R1 received the following medications: olanzapine 15 milligram (mg) at bedtime, polyethylene glycol 3350 17grams daily, Symbicort 80/4.5 aerosol inhale 2 puffs into lungs twice daily, and Tri-Lo-Estaryll 1 tablet daily. R1's Medication Administration Summary - Month dated March 1, 2025, through March 17, 2025, lacked medication administration documentation for the following medication administration opportunities during multiple shifts: 8:00 A.M. ADMINISTRATION - 1/17 polyethylene glycol 3350 17grams; - 1/17 Symbicort 80/4.5 aerosol inhaler; and - 1/17 Tri-Lo-Estaryll 8:00 P.M. ADMINISTRATION - 1/17 olanzapine 15 mg; and - 1/17 polyethylene glycol 3350 17grams. On March 17, 2025, at 12:37 p.m., clinical nurse supervisor (CNS)-C stated they were not aware why the medication administration was not charted on the above-mentioned shifts. CNS-C stated R1 goes on leave of absence a lot and staff might have forgotten to chart medication administration to reflect the leave of absence. The licensee's undated 1.20 Documentation Requirement for all Services Provided read, "[the licensee's name] requires all services provided to residents must be properly documented in the resident record. Proper documentation includes: 1. Document it- if you did not write it down, it did not happen. 2. Date, time and sign every documentation entry. 3. Documentation is to be done at the time of	01760		

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01760	Continued From page 45 the services, or ASAP after the service is provided. 4. Documentation should be legibly written. 5. Documentation must be objective in nature, avoiding opinions. Using correct medical terminology to describe the observation or interaction. 6. Include in the entry if the nurse was notified of a change or emergent condition/ situation. 7. Avoid abbreviations, unless approved by your Assisted Living Facility 8. Each staff member must document for themselves. Do not ask anyone or let anyone document on your behalf. Types of Documentation Records: 1. Paper Medication Administration Record (MAR), Electronic Medication Administration Record (eMAR). 2. Treatment Administration Record (TAR), Electronic Treatment Administration Record (eTAR). 3. Service Delivery documentation. 4. Communication books, shift to shift reports. 5. Narcotic Control Books/ forms. 6. Progress/ Nursing Notes. 7. Provider/ MD Communications. 8. Assessments, Care Plans, Service Plans 9. Other" No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the	01910		

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01910	Continued From page 46 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 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 provide documentation of disposition of medications for one of one discharged resident (R3). 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: R3 was admitted to the licensee on December	01910		

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01910	Continued From page 47 14, 2021, and discharged to the licensee's sister facility on May 1, 2024. R3 was readmitted to the licensee on March 16, 2025. R3's diagnoses included major depressive disorder, scoliosis, post-traumatic stress disorder, major anxiety, suicidal ideation, mild intellectual disability, borderline personality disorder and cognitive deficits. On March 17, 2025, at12:23 p.m., the surveyor observed ULP-A administer oral medication to R3. R3's physician order dated December 17, 2024, indicated R3 took the following medication: - trazadone 100 milligrams (mg) take one tablet (tab) by mouth at bedtime; - hydroxyzine HCL 50mg - Take 1 tab by mouth three times a day; - lamotrigine 100mg take ½ tab by mouth at bedtime; - loratadine 10mg, take 1 tab by mouth once daily; - lorazepam 1mg, take 1mg tablet by mouth at bedtime; - metformin HCL 100mg tab by mouth twice daily; - norethin ACE 5mg tab take ½ by mouth daily; - risperidone 3mg take one 3mg tab by mouth at bedtime; - senexon-s 50mg 8.6mg tab take 1 tab by mouth twice daily; - sertraline 100mg tab take 2 tabs by mouth in the morning; - Aspirin-acetaminophen-caffeine take 1 tab by mouth every six hours as needed (PRN) for pain; - Polyethylene glycol 3350 17 gram take by mouth once daily PRN; and - quetiapine fumarate 25mg tab take 1 tab by mouth daily PRN.	01910		

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01910	Continued From page 48 R3's record lacked evidence of documented disposition of medications for R3 to include: the name of the medication, strength, prescription number if applicable, quantity, to whom the medications were given, date of disposition, and the names of the staff and other individuals involved in the disposition. On March 18, 2025, at 2:15 p.m., licensed assisted living director (LALD)-D stated they did not do any paperwork (including assisted living contract) for R3's discharge or readmission as R3 got transferred with in the same company. On March 18, 2025, at 2:44 p.m., clinical nurse supervisor (CNS)-C stated they did not do any paperwork including admission assessment, service plan, individual abuse prevention plan, individual medication management plan, discharge summary, medication disposition, or individual treatment and therapy plan for R3 when R3 got readmitted to the licensee. CNS-C stated they transferred R3's physical chart to the licensee's sister facility upon discharge and they got the physical chart back from the sister facility upon readmission. CNS-C stated they were not aware of the requirement to do the above-mentioned paperwork when a resident moved to a different facility under the same ownership. The licensee's 7.23 Medication Disposal policy dated August 1, 2021, indicated any current medications being managed by the licensee 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 discontinued or have expired may	01910		

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01910	Continued From page 49 be provided for disposal. 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. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
02290 SS=F	144G.91 Subd. 2 Legislative intent The rights established under this section for the benefit of residents do not limit any other rights available under law. No facility may request or require that any resident waive any of these rights at any time for any reason, including as a condition of admission to the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee included language within a posting on a bulletin board located in common area in the living room which limited the rights of all residents residing within the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	02290		

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02290	Continued From page 50 The findings include: On March 17, 2025, at approximately 11:08 a.m., the surveyor observed a House Rules and Boundaries posting on a bulletin board located in common area in the living room, on the main floor. The posting contained the following: "Chores Individuals will be asked to participate and assist with normal daily household chores, such as emptying the trash, cleaning your room or washing your dishes, or vacuuming, or dusting your room. Individuals are expected to complete their chores to a reasonable quality standard and to the best of their ability. 15 . Supervision Individuals and staff will be expected to comply with the individual's supervision protocols approved by their team, at all times. Unless otherwise documented, individuals will remain within visual range when in the community. 16. Visitation Midwest Homes, Inc. discourages off-site visits for the individual's first 30 days following admission, so client has a gentle transition into the program. On-site visits are permitted following admission. Unless otherwise decided by the individual's team, visitors are welcome with 7 days advanced notice to arrange for staffing (when indicated) and to plan around community activities, mealtimes, medication times, etc. Visits should be coordinated with the Program Manager or Director." On March 17, 2025, at 1:05 p.m., licensed assisted living director (LALD)-D stated the residents are required to give 7-day notice to the licensee; Then the team must approve before	02290		

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02290	Continued From page 51 they can have visitors on site. LALD-D also stated residents cannot have visitors on site for 30 to 45 days until it was reviewed and approved by the team. On March 17, 2025, at 1:10 p.m., clinical nurse supervisor (CNS)-C stated the rules were against the residents right and stated they had to change. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02290		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the required notice was posted at the main entryway of the facility to display statutory language to disclose electronic monitoring activity. This had the potential to affect all of 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	03090		

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03090	Continued From page 52 or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The finding include: On March 17, 2025, at 10:21 a.m., the surveyor observed signage posted at the main entrance indicating the area is under 24 hours video surveillance. The signage did not include a statement to indicate electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities. On March 17, 2025, at 1:45 p.m., licensed assisted living director (LALD)-D stated they were cited for not having the right signage, on the last survey and corrected it the same day and they thought it fell off. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090		

Minnesota Department of Health
Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *03/17/25*
Time: 11:30:00
Report: 1039251098

Food and Beverage Establishment Inspection Report

Location:
Midwest Homes Inc
2445 10th Avenue South
Minneapolis, MN55404
Hennepin County, 27

Establishment Info:
ID #: 0038108
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6128651874
ID #:

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

The following orders were issued during this inspection.

3-500D Microbial Control: disposition of food

3-501.18A ***** Priority 1 *****

MN Rule 4626.0405A Discard all TCS food prepared in the establishment or opened commercially packaged food when the time exceeds 7 days from the preparation or opening date or if the container or package is not marked.

SOUR CREAM OPENED ON 3/6 HELD IN COOLER. FOOD DISCARDED. COMPLY WITH ABOVE RULE.

Comply By: 03/17/25

2-500 Responding to contamination events

2-501.11 ***** Priority 2 *****

MN Rule 4626.0123 Provide employees with procedures to follow for cleanup of vomit or fecal matter in the establishment. The procedures must minimize the spread of contamination to food and surfaces within the facility, and minimize the exposure of employees and consumers to contamination.

REISSUE FROM LAST INSPECTION NO VOMIT/FECAL MATTER CLEAN-UP PROCEDURES PRESENT. WRITTEN GUIDANCE ON TOPIC LEFT WITH PIC. PIC STATES THEY WILL ACQUIRE VOMIT CLEAN-UP KIT.

Comply By: 03/17/25

4-300 Equipment Numbers and Capacities

4-302.12B ***** Priority 2 *****

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

REISSUE FROM LAST INSPECTION NO FOOD PROBE THERMOMETER ON-HAND. COMPLY WITH ABOVE RULE. INSPECTOR SUGGESTS PROBE THERMOMETER WITH DIGITAL

READOUT.
Comply By: 03/17/25

4-300 Equipment Numbers and Capacities

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

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

REISSUE FROM LAST INSPECTION NO UTENSIL SURFACE TEMPERATURE MEASURING DEVICE. COMPLY WITH ABOVE RULE.
Comply By: 03/17/25

4-400 Equipment Location and Installation

4-402.11A

MN Rule 4626.0725A Space fixed equipment to allow access for cleaning along the sides, behind and above the unit, or seal to adjoining equipment or walls.

COUNTERTOP JOINT AT WALL IS BADLY DAMAGED, PULLED AWAY FROM WALL. REPAIR AND RESEAL TO WALL.
Comply By: 04/01/25

Food and Equipment Temperatures

Process/Item: MILK
Temperature: 38 Degrees Fahrenheit - Location: COLD HOLD IN COOLER
Violation Issued: No

Process/Item: FROZEN
Temperature: Degrees Fahrenheit - Location: FREEZER
Violation Issued: No

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

The inspection was completed with the person in charge and reviewed with MDH nurse evaluator Derartu Mosissa.

The kitchen is of residential build and should serve food for same-day service only.

The kitchen has wood cabinets with hollow base and laminate countertops, laminate wood floor, painted walls and ceiling. These kitchen finishes and surfaces are clean and well maintained, save for order on countertop/wall junction written above.

The kitchen refrigerator/freezer are of residential grade.

A 2-compartment sink is present in kitchen. 1 compartment is designated for handwashing only.

A residential dishwashing machine is present in the kitchen. During inspection, a run of the dish machine was started with a color-change thermos test strip. Results of the run where shared by person-in-charge via email showing a rinse temperature of 160 degrees F.

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A supply of single-use gloves is present in kitchen. A supply of single-use sanitizing wipes for food contact surfaces is present in kitchen.

Discussed the following with the person-in-charge: minimum cook temps for animal proteins, food source, foodborne illness symptoms and exclusion of ill employees, avoiding bare hand contact with ready to eat foods, handwashing, sanitizing., all orders on this report.

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 1039251098 of 03/17/25.

Certified Food Protection Manager: Boakai Kiandoli

Certification Number: FM123135 Expires: 05/03/27

Inspection report reviewed with person in charge and emailed.

Signed: _____

Regina Stepney
person-in-charge

Signed: _____

Aron Goodner
Public Health Sanitarian I
Freeman Building
aron.goodner@state.mn.us