Electronically Delivered
April 29, 2024

Licensee
Absolute Homes, Inc.
3045 Central Avenue North East
Minneapolis, MN 55418

RE: Project Number(s) SL36793015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 10, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued,

including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

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

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

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

If you have any questions, please contact me.

Sincerely,

Renee L. Anderson

Renee L. Anderson, Supervisor
State Evaluation Team
Email: renee.l.anderson@state.mn.us
Telephone: 651-201-5871 Fax: 1-866-890-9290

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36793	A. BUILDING: _____ B. WING _____	04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABSOLUTE HOMES INC	3045 CENTRAL AVENUE NORTH EAST MINNEAPOLIS, MN 55418

(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: SL36793015-0 On April 8, 2024, through April 10, 2024, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were four residents, three of whom received services under the provider's Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level pursuant to 144G.31 Subd. 1, 2 and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according	0 480		

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0 480	Continued From page 1 to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated April 8, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies	0 680		

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0 680	Continued From page 2 temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview, and record review the licensee failed to have a written emergency preparedness plan (EP) with all the required content. 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:	0 680		

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0 680	Continued From page 3 The licensee's emergency preparedness plan lacked the following required content: -documentation of two emergency preparedness exercises (an annual full-scale exercise or individual facility-based functional exercise and a second full-scale exercise that was either community-based, an individual facility based functional exercise, a mock disaster drill, or a table-top exercise). On April 9, 2024, at 1:50 p.m., owner/unlicensed personnel (O/ULP)-A stated the licensee had not conducted an annual full-scale exercise or second annual exercise. The licensee's 9.01 Emergency Preparedness Plan-Appendix Z Compliance policy, dated August 1, 2023, indicated "[licensee] will conduct, at minimum, two emergency preparedness drills every 12 months - these drills to not include required fire/evacuation drills. One annual exercise will be a full-scale community wide exercise. The second annual exercise will either be a second full-scale community-wide exercise or a tabletop exercise." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:	0 780		

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0 780	Continued From page 4 (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide interconnected smoke alarms throughout the facility. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include:	0 780		

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0 780	Continued From page 5 On a facility tour on April 9, 2024, at 11:30 a.m., with owner/unlicensed personnel (O/ULP)-A, it was observed that smoke alarms were not interconnected so activation of one alarm activates all alarms throughout the facility. All dwelling units required to have multiple smoke alarms are required to have interconnected alarms so activation of one alarm activates all alarms within the dwelling unit. During the tour the smoke alarms were tested and O/ULP-A, verified the smoke alarms were not interconnected so activation of one alarm activates all alarms throughout the facility. TIME PERIOD FOR CORRECTION: Two (2) day.	0 780		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter.	0 810		

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0 810	Continued From page 6 (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content, make the plan readily available, provide 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 April 9, 2024, at 2:15 p.m., owner/ unlicensed personnel (O/ULP)-A, provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for	0 810		

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0 810	Continued From page 7 the facility. FIRE SAFETY AND EVACUATION PLAN The licensee FSEP dated August 1, 2023, failed to include the following: The FSEP included standard employee procedures, but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan failed to include updated and accurate procedures for employees during a fire or similar emergency. The FSEP did not identify specific fire protection actions for residents evident by not providing procedures for residents during a fire or similar emergency. Procedures for residents during a fire or similar emergency are required to be provided in writing in the FSEP. 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 failed to include resident evacuation status/ unique needs for each individual resident evacuation during a fire or similar emergency. During an interview on April 9, 2024, at 2:30 p.m., O/ ULP-A stated employee procedures and resident procedures during a fire or similar emergency and resident evacuation status/ unique needs were not included in writing in the FSEP. TRAINING	0 810		

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0 810	Continued From page 8 Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and at least twice per year as evident by not providing documentation the training was provided as required. During an interview on April 9, 2024, at 2:40 p.m., O/ ULP-A, stated documentation was not available for the required training. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift as evident by providing documentation evacuation drills were conducted every other month but all drills were completed for the same shift. During an interview on April 9, 2024, at 2:50 p.m., O/ ULP-A stated documentation was not available to indicate drills were conducted twice per year per shift. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law.	0 970		

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0 970	Continued From page 9 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all the licensees residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: R1's record included an Assisted Living Contract, signed on August 1, 2021. The Assisted Living Contract included the following section, indicating a waiver of liability: Indemnification: The licensee "shall not be liable for any damage or injury to the resident, or any other person, or to any property, occurring on the premises, or any part thereof, or in common areas thereof, and the resident agrees to hold [the licensee] harmless from any claims or damages unless caused solely by negligence of [the licensee]. It is recommended that renter's insurance be purchased at the resident's expense. Nothing contained herein is intended to create a waiver of facility liability for the health and safety or personal property of a resident." On April 10, 2024, at 11:50 a.m.,	0 970		

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0 970	Continued From page 10 owner/unlicensed personnel (O/ULP)-A stated they were not aware the above referenced language was prohibited, and verified the same contract was used for all residents. O/ULP-A further stated they would change the language to meet requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact	01060		

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01060	Continued From page 11 information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation for one of one 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 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: R3's diagnoses included leaky heart valve.	01060		

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01060	Continued From page 12 R3's Service Plan, dated May 28, 2022, indicated R3 received services including medication administration, grooming and behavior management. R3's Resident Notes dated September 17, 2023, at 5:35 a.m., indicated R3 had an emergency relocation to the hospital due to his appendix. R3's Resident Notes dated September 18, 2023, at 11:05 a.m., indicated R3's services had been put on hold and would resume "when he returns." R3's record lacked evidence of a written notice provided to the resident, the residents' legal representative, and designated representative that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident had been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care (OOLTC); - if known and applicable, the approximate date or range of dates within which the resident was expected to return to the facility, or a statement that a return date was not currently known; and - a statement that, if the facility refused to provide housing or services after a relocation, the resident had the right to appeal and the contact information for the agency to which the resident may submit an appeal. On April 9, 2024, at 1:55 p.m., registered nurse (RN)-B stated a written notice had not been provided with the required content, and the OOLTC had not been notified. In addition, RN-B stated she was not aware an emergency relocation notification needed to be provided.	01060		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36793	A. BUILDING: _____ B. WING _____	04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABSOLUTE HOMES INC	3045 CENTRAL AVENUE NORTH EAST MINNEAPOLIS, MN 55418

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01060	Continued From page 13 The licensee's Discharge and Transfer of Residents policy, dated August 1, 2021, indicated a written notice of an emergency relocation would be provided to the resident, the resident's legal representative, the resident's case manager (if applicable), and the Ombudsman for Long Term Care. The policy lacked wording to indicate the specific information to be provided, as noted above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36793	A. BUILDING: _____ B. WING _____	04/10/2024

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01290	Continued From page 14 employee had a cleared Minnesota Department of Human Services (DHS) NETStudy 2.0 background study for three of three employees (registered nurse (RN)-B, unlicensed personnel (ULP)-C, ULP-D). This had the potential to affect all residents in 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). The findings include: RN-B, ULP-C, ULP-D were hired January 28, 2021, July 28, 2021, and January 28, 2021, respectively, to provide direct care services to residents. On March 8, 2024, at 1:00 p.m., ULP-C was observed to assist R2 with medication administration. ULP-C was unsupervised during the observation. RN-B, ULP-C, and ULP-D's records included DHS background studies dated January 22, 2021, July 17, 2021, and January 21, 2021, respectively. On March 9, 2024, at 9:50 a.m.,the DHS NETStudy 2.0 Roster was reviewed with the owner (O)/ULP-A. The roster indicated RN-B, ULP-C, and ULP-D's background studies were initiated under a COVID-19 waiver, which expired December 31, 2022. O/ULP-A stated RN-B, ULP-C, and ULP-D had not been fingerprinted	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36793	A. BUILDING: _____ B. WING _____	04/10/2024

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01290	Continued From page 15 since the waiver ended, and he was unaware they needed to be. O/ULP-A further stated he "will get on it right away." -at 1:30 p.m., O/ULP-A stated the employees had been fingerprited for the providers previous home care license. O/ULP-A accessed the provider's previous license NETStudy 2.0 Roster on line for the surveyor to observe, which indicated the employees were eligible and had been fingerprinted under the previous license. The MN DHS website Frequently Asked Questions (FAQs) on Background Studies, updated July 20, 2023, indicated emergency studies initiated during the COVID-19 pandemic were no longer valid. The website indicated, "If an individual who is still affiliated has not had a new fingerprint-based background study submitted since their emergency study expired, then your entity is not compliant with state and federal background study requirements. A new fingerprint-based study must be submitted immediately in NETStudy 2.0 for individuals who do not have one." The licensee 4.02 Background Studies policy dated August 1, 2021, indicated no employee would provide direct care services or have independent direct contact with any resident until an acceptable background study had been received. No further information was provided. TIME PERIOD OF CORRECTION: Two (2) days	01290		

Minnesota Department of Health
Food, Pools, and Lodging Services
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *04/08/24*
Time: 11:00:00
Report: 1013241035

Food and Beverage Establishment Inspection Report

Location:
Absolute Homes Inc
3045 Central Avenue North East
Minneapolis, MN55418
Hennepin County, 27

Establishment Info:
ID #: 0037842
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6122299512
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.

3-500B Microbial Control: hot and cold holding

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

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

COLD TCS FOOD ABOVE 41F IN THE KITCHEN REFRIGERATOR: CHEESE 48F, MILK 49F, DELI MEAT 49F, YOGURT 47F. DISCUSSED TEMPERATURE CONTROL WITH STAFF. REFRIGERATOR WAS TURNED COLDER.

4:30 PM
STAFF SENT PICTURES TO MDH OF TCS FOOD HOLDING AT 41F OR BELOW.

Comply By: 04/08/24

4-300 Equipment Numbers and Capacities

4-302.12A ***** Priority 2 *****

MN Rule 4626.0705A Provide a readily accessible food temperature measuring device to ensure attainment and maintenance of food temperatures.

NO FOOD PROBE THERMOMETER CAPABLE OF MEASURING HOT AND COLD TEMPERATURES WAS AVAILABLE. COMPLY WITH ABOVE RULE. DISCUSSED THERMOMETER USE WITH STAFF.

4:30 PM
STAFF SENT MDH PICTURES OF FACILITY'S FOOD PROBE THERMOMETER.

Corrected on Site

2-100 Supervision

2-102.12AMN

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

NO MN CFPM WAS EMPLOYED AT THE FACILITY. AN EMPLOYEE HAD A CURRENT FOOD MANAGERS COURSE CERTIFICATE. THE MN CFPM INFORMATION WAS PROVIDED.

Comply By: 05/06/24

4-200 Equipment Design and Construction

4-201.11GMN

MN Rule 4626.0506G Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

THE FACILITY HAS A RESIDENTIAL KITCHEN. SOUP/STEW COOKED BY STAFF THEN COOLED ON 4/7/24 WAS STORED IN THE RESIDENTIAL REFRIGERATOR. COMPLY WITH ABOVE RULE. DISCUSSED FOOD SERVICE OPERATION WITH STAFF INCLUDING SAME DAY SERVICE. FOOD DISCARDED.

Comply By: 04/08/24

Surface and Equipment Sanitizers

Hot Water: = at 160 Degrees Fahrenheit
Location: Dish machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cheese
Temperature: 48 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: Yes

Process/Item: Milk
Temperature: 49 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: Yes

Process/Item: Yogurt
Temperature: 47 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: Yes

Process/Item: Deli meat
Temperature: 49 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: Yes

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

The inspection was completed with the operator then reviewed with MDH Nurse Evaluator T. Carlson.

The establishment has a residential kitchen and should only serve food that is prepared that day. The kitchen has wood cabinets, vinyl floor, painted walls, solid counter top, and a smooth painted ceiling.

A two basin sink was located in the kitchen. One basin was designated for hand washing.

A residential dish machine is used to wash ware. The dish machine is run on the sanitize/high temperature cycle. A picture of the facility's test kit was sent to the inspector.

Discussed hand washing, ware washing, staff illness policy, temperature control, final cook temperatures, cleaning, serving highly susceptible populations, glove use, and food handling procedures.

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 1013241035 of 04/08/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____

Mohamud Haille
Operator

Signed:_____

Jerry Malloy
Sanitarian Supervisor
FPLS Metro
651-201-3998
jerry.malloy@state.mn.us