Electronically Delivered

August 30, 2024

Licensee
Cerenity Residence of White Bear Lake
4615 2nd Avenue
Birchwood, MN 55110

RE: Project Number(s) SL30429015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 31, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30429	A. BUILDING: _____ B. WING _____	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY RESIDENCE OF WHITE BEAR LAKE	4615 2ND AVENUE BIRCHWOOD, MN 55110

(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: SL30429015-0 On July 29, 2024, through July 31, 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 29 residents, all of whom were receiving services under the provider's Assisted Living Facility 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.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of	0 470		

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0 470	Continued From page 1 staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to develop and implement a staffing plan to meet the scheduled and reasonably foreseeable unscheduled needs of the residents. 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	0 470		

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0 470	Continued From page 2 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: R2 R2 admitted on October 4, 2020, with diagnoses including osteoporosis (weakened bone strength). R2's Resident Evaluation, dated June 27, 2024, indicated R2 was independent with ambulation and used a four-wheeled walker. A fall report, dated July 23, 2024, indicated R2 fell on July 20, 2024, at 12:00 a.m. The report further indicated staff had been directed by the on-call triage nurse to call emergency medical services (EMS) to assist R2 off the floor. R8 R8 admitted on June 1, 2019, and discharged March 25, 2023, with diagnoses including Parkinson's disease (a progressive disorder that affects the nervous system). A Resident Evaluation, dated December 31, 2023, indicated R8 required assistance of one staff with transfers. A fall report dated March 19, 2024, indicated R8 fell on March 17, 2024, at 6:45 p.m., and EMS had been called to assist with lifting the resident off the floor. The report further indicated R8 was assisted off the floor and back into bed by EMS. On July 29, 2024, at 3:15 p.m., unlicensed personnel (ULP)-D stated she had utilized emergency services in the past to assist with getting a resident off the floor when the resident	0 470		

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0 470	Continued From page 3 was too heavy, and she was not able to get them up alone. On July 30, 2024, at 7:30 a.m., ULP-E stated if a resident were "heavier" she would call emergency services to assist with getting a resident up off the floor. On July 31, 2024, at 11:15 a.m., clinical nurse supervisor (CNS)-B stated staff might be directed to call emergency services for a fall if the staff member felt uncomfortable getting the person up by themselves. Regional director (RD)-A stated she was not aware EMS should not be regularly used to assist residents in getting up from the floor. The licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) dated June 7, 2024, noted the number of unlicensed direct care staff typically scheduled was two for the day shift and one for the evening and night shift. The UDALSA further indicated transfers with an assist of one staff was available. The licensee's BHS Fall Prevention and Reduction policy, dated 2021, indicated staff would call EMS if directed by the registered nurse and the resident appeared to be injured or in need of urgent medical care. The policy further indicated staff would assist the resident off the floor if urgent care were not needed. The licensee's Direct-care staffing: Plan, Scheduling and Posting policy, reviewed March 4, 2022, indicated the staffing plan would provide staff sufficient to meet the residents' needs 24-hours a day, seven-days a week and would adequately meet the residents' scheduled and reasonably unforeseeable unscheduled needs.	0 470		

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0 470	Continued From page 4 No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated July 29, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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0 480	Continued From page 5 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that complied with fire protection requirements. This had the potential to directly affect all residents, staff, and	0 780		

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0 780	Continued From page 6 visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 31, 2024, at 10:50 a.m., survey staff toured the facility with executive director (ED)-F, licensed assisted living director (LALD)-A, and maintenance staff (MS)-G. During the tour, LALD-A tested smoke alarms in resident apartments. In apartments 101, 111, 113, 210, 211, and 311 survey staff observed when the smoke alarms were tested, all of the dwelling unit smoke alarms were not actuated. The smoke alarms in these individual dwelling units were not interconnected as required by statute. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on	01640		

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01640	Continued From page 7 resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a current written service plan included a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided for one of three residents (R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R6 was admitted on March 6, 2024, with diagnoses to include heart failure and prostate cancer. A provider order, dated July 3, 2024, indicated R6	01640		

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01640	Continued From page 8 was to apply lymph wraps (also known as compression wraps) daily. On July 30, 2024, at 6:40 a.m., the surveyor observed unlicensed personnel (ULP)-E assist R6 with applying velcro compression wraps to both lower legs. R6's signed service plan, dated July 31, 2024, during the time of survey, indicated R6 received services to include assistance with applying velcro compression wraps to legs daily. On July 31, 2024, at 11:10 a.m., clinical nurse supervisor (CNS)-C stated the addition of the velcro wraps had been added to the service plan, but the service plan had not been signed at the time it was added. CNS-C further stated she did not think a new service plan needed to be signed because the service level had not changed, but "moving forward we will get the service plan signed as soon as anything is added." The licensee's Service Plan policy, dated 2021, indicated, "the service plan and any revisions must include a signature or other authentication by the facility and by the resident or the resident's representative documenting agreement on the services to be provided." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01810 SS=D	144G.71 Subd. 12 Medications; over-the-counter drugs; dietary An assisted living facility providing medication	01810		

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01810	Continued From page 9 management services for over-the-counter drugs or dietary supplements must retain those items in the original labeled container with directions for use prior to setting up for immediate or later administration. The facility must verify that the medications are up to date and stored as appropriate. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure over the counter (OTC) drugs were stored as appropriate 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 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 admitted on November 9, 2023, with diagnoses to include Alzheimer's disease (a brain disorder that causes memory loss, thinking problems, and personality changes), depression, anxiety, and macular degeneration (an age-related eye condition affecting central vision). R3's Service Plan with Schedule, dated June 18, 2024, and R3's Medication Management Assessment, dated July 8, 2024, indicated R3 required assistance with medication administration.	01810		

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01810	Continued From page 10 R3's Resident Evaluation, dated July 8, 2024, which included medication administration instructions, indicated R3 required staff to administer pills or liquids, and staff to assist with storage and preparation. On July 30, 2024, at 7:50 a.m., the surveyor observed unlicensed personnel (ULP)-D administer R3's morning medications from a medication container locked in R3's kitchen cabinet. Upon entering R3's bedroom, the surveyor observed one bottle of Rolaids, with an expiration date of November 2022, on R3's bedside table. ULP-D stated she did not recall seeing this bottle of Rolaids in her bedroom prior to this observation. Further, ULP-D verbalized she would take this medication to the nurse. -7:58 a.m., the surveyor asked R3 if she had recently taken the Rolaids located on her bedside table, R3 stated "yes, I took them last night because the dining room served me soup last night with onions in it, and it upset my stomach." R3's signed physician orders, dated February 7, 2024, included an anti-depressant, vitamin supplements, pain relievers, indigestion medication, eye drops, and cough suppressant lozenges and liquid, but lacked a scheduled dose, or as needed dose of Rolaids to be administered for R3. On July 30, 2024, at 8:05 a.m., clinical nurse supervisor (CNS)-C and regional director (RD)-B stated, they required a prescription for all over the counter medications and supplements for all residents who received assistance with medication administration. Also, CNS-C stated R3's expired Rolaids should have been brought to the nurse for medication disposition. Further, CNS-C verbalized a family member must have	01810		

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01810	Continued From page 11 brought this to R3 and CNS-C planned to talk to the family. The undated document titled Rolaids Tablet, Chewable - Uses, Side Effects, and More indicated, "Storage: Store at room temperature away from light and moisture. Do not store in the bathroom. Keep all medications away from children and pets. Do not flush medications down the toilet or pour them into a drain unless instructed to do so. Properly discard this product when it is expired or no longer needed. Consult your pharmacist or local waste disposal company." The licensee's Storage of Medication policy dated March 3, 2022, included "Purpose: To ensure proper storage of medications managed by the community." Also, indicated "1. A registered nurse must conduct a face to face nursing assessment of a client's need for medication management services, including the appropriate method to store the client's medications and whether secured storage is appropriate given the client's functional and cognitive status, concerns about the potential for drug diversion or other considerations. Based on this assessment, the RN will develop an individualized medication management plan for the client that will address storage of the client's medications." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01810		

DEPARTMENT OF HEALTH

Environmental Health
Food, Pools, and Lodging
625 Robert St. N
St. Paul
651-201-5000

Type: Full
Date: *07/29/24*
Time: 11:00:00
Report: 1031241185

Food and Beverage Establishment Inspection Report

Location:
Cerenity Residence Of Wbl
4615 2nd Avenue
White Bear Lake, MN55110
Ramsey County, 62

Establishment Info:
ID #: 0038445
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6512321868
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.

4-700 Sanitizing Equipment and Utensils

4-703.11C ***** Priority 1 *****

MN Rule 4626.0905C Sanitize food contact surfaces of equipment and utensils after cleaning by using an approved chemical sanitizer in manual or mechanical operations for at least 7 or 10 seconds for chlorine depending on temperature, concentration, and pH; and 30 seconds for all other chemical sanitizers or a contact time used in relation with a combination of temperature, concentration, and pH.

SANITIZER DISPENSER CONCENTRATION MEASURED 0PPM. ***DISCONTINUE USE OF SANITIZER DISPENSER UNTIL REPAIRED.*** MAKE BLEACH AND WATER SOLUTION USING TEST STRIPS TO CHECK CONCENTRATION (50-200ppm) UNTIL REPAIR COMPLETED.

Comply By: 07/29/24

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.

ESTABLISHMENT MISSING IRREVERSIBLE MEASURING DEVICES IN ASST LVNG AND MAIN KITCHENS. PROVIDE IRREVERSIBLE MEASURING AND MEASURE UTENSIL TEMPERATURE (160F REQUIRED) AT REGULAR INTERVALS.

Comply By: 08/01/24

4-300 Equipment Numbers and Capacities

4-302.14 ***** Priority 2 *****

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

ESTABLISHMENT DOES NOT HAVE BLEACH OR QUAT SANITIZER TESTING KIT ON SITE. PURCHASE KITS AND TEST SANI CONCENTRATION (50-200PPM BLEACH, 150-400PPM QUAT).

Comply By: 08/01/24

4-600 Cleaning Equipment and Utensils

4-601.11A ***** Priority 2 *****

MN Rule 4626.0840A Equipment food-contact surfaces and utensils must be clean to sight and touch.

2 CAN OPENERS FOUND WITH FOOD BUILDUP ON BLADE. HAD CAN OPENERS SENT TO DISH FOR CLEANING. CLEAN CAN OPENERS DAILY AFTER USE.

CORRECTED ON SITE.

Comply By: 08/19/24

7-100 Toxic Labeling

7-102.11 ***** Priority 2 *****

MN Rule 4626.1595 Clearly label all working containers used for storing poisonous or toxic materials from bulk supplies such as sanitizers and cleaners, with the common name of the product.

CHEMICAL BOTTLES IN ASST LVNG AND MAIN KITCHENS DID NOT HAVE LABELS.

Comply By: 08/01/24

2-100 Supervision

2-102.12AMN

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

ESTABLISHMENT DOES NOT HAVE A CERTIFIED FOOD PROTECTION MANAGER (CFPM). KITCHEN PIC CURRENTLY TAKING COURSE.

Comply By: 08/19/24

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.

THE FOLLOWING ITEMS NEED REMOVAL OF OLD SILICONE, CLEAN AREA, AND RESEAL WITH 100% SILICONE.

1. CLEAN AND SOIL TABLES - ATTACH TRIM TO WALL PRIOR TO SILICONING.
2. MAIN KITCHEN PREP TABLE - HAVE STAINLESS TRIM PIECE MADE IF UNABLE TO SILICONE.

Comply By: 08/19/24

4-500 Equipment Maintenance and Operation

4-501.11AB

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

1. HOSHI COOLER IN ASST LVNG NOT FUNCTIONAL. FOOD REMOVED FROM COOLER. REPAIR COOLER.
2. TRUE 3-DOOR AND WALK-IN FREEZERS HAVE ICING AROUND DOORS. REMOVE ICE. HAVE FREEZERS REPAIRED IF ICE RETURNS.
3. ICE MACHINE BIN LEAKING. REPAIR OR REPLACE BIN.

Comply By: 08/19/24

4-600 Cleaning Equipment and Utensils

4-601.11B

MN Rule 4626.0840B Maintain the food contact surfaces of cooking equipment and pans free of encrusted grease deposits and other soil accumulations.

RIGHT CONVECTION OVEN STACK - INTERIOR FOUND WITH ENCRUSTED FOOD DEBRIS THROUGHOUT CAVITY. CLEAN AND MAINTAIN CLEAN.

Comply By: 08/19/24

4-600 Cleaning Equipment and Utensils

4-602.13

MN Rule 4626.0855 Clean all non-food-contact surfaces of equipment at a frequency necessary to preclude accumulation of soil residues.

1. HOOD FILTERS IN ASST LVNG HAVE DUST DEBRIS. CLEAN FILTERS.
2. PICK OFF PLASTIC AND CLEAN TOP OF STEAMER.

Comply By: 08/12/24

4-900 Protecting Clean Items

4-903.11B

MN Rule 4626.0955B Store all clean equipment and utensils in a self-draining position that permits air drying, and covered or inverted.

OBSERVED MULTIPLE PANS STACKED TOGETHER WHILE WET. ALLOW ALL PANS TO DRY COMPLETELY PRIOR TO STACKING.

Comply By: 08/19/24

6-100 Physical Facility Construction Materials

6-101.11A3

MN Rule 4626.1325A3 Provide nonabsorbent floor, wall, and ceiling surfaces for food preparation areas, walk-in refrigerators, warewashing areas, toilet rooms, all servicing areas, and areas subject to flushing or spray cleaning methods.

ABSORBENT ACOUSTIC CEILING TILES USED IN DRY STORAGE AREA WHERE RTE FOOD IS ALSO HELD. REPLACE ACOUSTIC TILES WITH NON-ABSORBENT TILES TO COMPLY WITH ABOVE RULE.

Comply By: 08/19/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.

VENT PIPE ABOVE ASST LVNG DISH AREA LEAKING/DRIPPING, CAUSING WATER HAZARD ON FLOOR. CORRECT VENT PIPE ISSUE.

Comply By: 08/19/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

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

THE FOLLOWING WALLS HAVE DIRT/GREASE ON SURFACES.

1. CLEAN WALL AND OUTLETS ABOVE PREP TABLE.
2. CLEAN WALL TO LEFT OF COOK LINE HOOD.

Comply By: 08/19/24

Surface and Equipment Sanitizers

Quaternary Ammonia: = 50 at Degrees Fahrenheit
Location: Sanitizer Dispenser
Violation Issued: Yes

Hot Water: = at 165 Degrees Fahrenheit
Location: Dish Machine (asst living)
Violation Issued: No

Hot Water: = at 162 Degrees Fahrenheit
Location: Dish Machine (main kitchen)
Violation Issued: No

Ambient Air Temp: = at 34 Degrees Fahrenheit
Location: Milk Cooler
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Hot Hold/Water
Temperature: 205 Degrees Fahrenheit - Location: Steam Table
Violation Issued: No

Process/Item: Cold Hold/Deli Trukey
Temperature: 40 Degrees Fahrenheit - Location: Advantco Cooler (assist living)
Violation Issued: No

Process/Item: Cold Hold/Cottage Cheese
Temperature: 36 Degrees Fahrenheit - Location: Hobart 3-Door Cooler
Violation Issued: No

Process/Item: Cold Hold/Lettuce
Temperature: 39 Degrees Fahrenheit - Location: Walk-in Cooler
Violation Issued: No

Process/Item: Cold Hold/Soup
Temperature: 40 Degrees Fahrenheit - Location: 2-Door (thaw) Cooler
Violation Issued: No

Process/Item: Reheating/Soup
Temperature: 189 Degrees Fahrenheit - Location: Pan in Oven
Violation Issued: No

Type: Full
Date: *07/29/24*
Time: 11:00:00
Report: 1031241185
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Food and Beverage Establishment Inspection Report

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

Nurse Evaluator on site: Tammy Carlson

All violations discussed with PIC during the inspection.

NOTES:

- Establishment uses pasteurized eggs for undercooked preparations.

- Establishment needs to check dish washer utensil temperature weekly (160F required). If utensil temp not reaching 160F, use washer to wash/rinse and sink basin with sanitizer solution to sanitize dishes then air dry, as discussed during inspection.

Discussed:
- Illness and illness recording
- Meat temps
- Reheating temps
- Glove use
- General Cleaning

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Environmental Health inspection report number 1031241185 of 07/29/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/__/_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Ariel Miller
Executive Director

Signed:_____
Chris Foster
Public Health Sanitarian II
Freeman Office Building
651-983-8760
chris.j.foster@state.mn.us