Electronically Delivered

April 8, 2025

Licensee
Midwest Group Home LLC
4232 5th Street Northeast
Columbia Heights, MN 55421

RE: Project Number(s) SL36754015

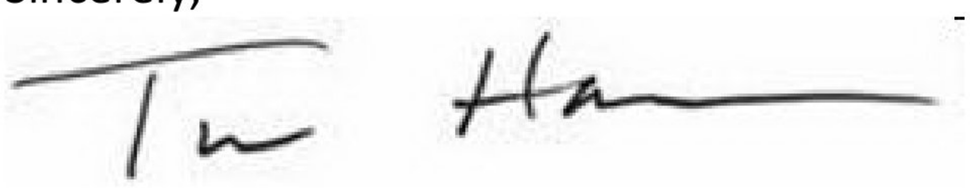
Dear Licensee:

On January 7, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the October 2, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,



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

HHH

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

February 5, 2025

Licensee
Midwest Group Home LLC
4232 5th Street Northeast
Columbia Heights, MN 55421

RE: Project Number(s) SL36754015

Dear Licensee:

On November 26, 2024, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on October 2, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the October 2, 2024 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on October 2, 2024, found not corrected at the time of the November 26, 2024, follow-up survey and/or subject to penalty assessment are as follows:

0820-Fire Protection And Physical Environment-144g.45 Subd. 2 (g)

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

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 outlined on the state form; however, plans of correction are not required to be submitted for approval.

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

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

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

Sincerely,

Tim Hanna, Supervisor
State Engineering Services Section
Email: Tim.Hanna@state.mn.us
Telephone: 507-208-8982 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
	36754	A. BUILDING: _____ B. WING _____	R 11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST GROUP HOME LLC	4232 5TH STREET NE COLUMBIA HEIGHTS, MN 55421

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL36754015-1 On 11-25-24, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on 11-25-24. At the time of the survey, there were three residents; three receiving services under the Assisted Living/Assisted Living with Dementia Care license. As a result of the follow-up survey, the following orders were reissued.	{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 Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	{0 680}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{0 680}	Continued From page 1 (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:	{0 680}	Not reviewed during this survey	
{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	{0 780}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36754	A. BUILDING: _____ B. WING _____	R 11/26/2024

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MIDWEST GROUP HOME LLC	4232 5TH STREET NE COLUMBIA HEIGHTS, MN 55421

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{0 780}	Continued From page 2 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:	{0 780}	Not reviewed during this survey	
{0 790} SS=F	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced	{0 790}		

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{0 790}	Continued From page 3 by:	{0 790}	Not reviewed during this survey	
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by:	{0 800}	Not reviewed during this survey	
{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	{0 810}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{0 810}	Continued From page 4 upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for 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:	{0 810}	Not reviewed during this survey	
{0 820} SS=G	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction.	{0 820}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{0 820}	Continued From page 5 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedrooms with the minimum window opening meeting the minimum state standard for egress. This affected all residents in the facility. This practice resulted in a level two violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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 October 14, 2024, at 9:00 a.m., survey staff spoke with the facility licensed assisted living director (LALD)-A. The LALD-A stated the deficiencies have not been addressed as of October 14, 2024. The LALD-A stated the window was ordered and was to be installed in December. On December 16, 2024, LALD-A provided documentation supporting the claim the window has been ordered and a contractor is scheduled to complete the work. LALA-A stated the bedroom was presently unoccupied. FINDINGS FROM INITIAL SURVEY ON OCTOBER 1, 2024: It was observed that occupied resident bedroom 5 on the lower level did not have window that met the minimum size requirements for egress escape. The clear openable area of the opened	{0 820}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{0 820}	Continued From page 6 window measured 20 inches in wide and 30.75 inches in height, with a total openable area of 615 square inches. The window did not meet the minimum requirements for a total openable area. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. Survey staff explained to LALD-A that at least one egress window in each bedroom must be provided to meet the minimum state standard for an egress window to be a complying bedroom for resident occupancy. LALD-A verbally confirmed the findings. On October 1, 2024, at 2:30 p.m., during the interview, survey staff explained to LALD-A that an immediate correction order was issued for the above finding. LALD-A acknowledged the above finding. No further information was provided.	{0 820}		
{0 830} SS=F	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements, except a facility with a licensed resident capacity of six or fewer is exempt from rental licensing regulations imposed by any town, municipality, or county. This MN Requirement is not met as evidenced	{0 830}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{0 830}	Continued From page 7 by:	{0 830}	Not reviewed during this survey	
{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 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:	{01760}	Not reviewed during this survey	
{01960} SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs.	{01960}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{01960}	Continued From page 8 This MN Requirement is not met as evidenced by:	{01960}	Not reviewed during this survey	

Electronically Delivered

October 31, 2024

Licensee
Midwest Group Home LLC
4232 5th Street Ne
Columbia Heights, MN 55421

RE: Project Number(s) SL36754015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 2, 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,

Jessie Chenze, Supervisor
State Evaluation Team
Email: Jessie.Chenze@state.mn.us
Telephone: 218-332-5175 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
	36754	A. BUILDING: _____ B. WING _____	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST GROUP HOME LLC	4232 5TH STREET NE COLUMBIA HEIGHTS, MN 55421

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0 000	Initial Comments 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: SL36754015-0 On October 1, 2024, through October 2, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were four resident(s); four residents receiving services under the Assisted Living Facility license. An immediate order for correction was identified on October 1, 2024, issued for SL36754015-0, tag identification 0820. On October 3, 2024, the immediacy of correction order 0820 was removed, however non-compliance remained, and the scope and level remained unchanged.	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 Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680		

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0 680	Continued From page 1 (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 develop a written emergency preparedness plan (EPP) with all the required content. In addition, the licensee failed to review the missing resident plan at least quarterly. This had the potential to affect all residents, staff, and visitors of 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	0 680		

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	36754	A. BUILDING: _____ B. WING _____	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST GROUP HOME LLC	4232 5TH STREET NE COLUMBIA HEIGHTS, MN 55421

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0 680	Continued From page 2 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's EPP undated, lacked the following content to address: -identifying at risk population needs like maintaining independence, communication, transportation, supervision and medical care; -subsistence needs for staff and residents; -policies and procedures for volunteers; and -missing resident plan that was reviewed quarterly. On October 2, 2024, at 12:32 p.m., licensed assisted living director (LALD)-A stated she was unable to find documentation the missing resident policy was reviewed quarterly and was aware of the requirement. LALD-A stated she was unable to find a policy and procedure on the use of volunteers and was not aware of the requirement. The licensee's Emergency Preparedness policy dated July 15, 2024, referenced: CMS State Operations Manual Appendix Z: MN Rules 4659.0100, indicted the licensee would have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0100, sections A and B, effective October 2022, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part	0 680		

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0 680	Continued From page 3 references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0110, Subp. 4, effective October 2022, the LALD and clinical nurse supervisor (CNS) must review the missing resident plan at least quarterly and document any changes to the plan. 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: (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	0 780		

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0 780	Continued From page 4 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 in the dwelling unit. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On October 1, 2024, at 1:30 p.m., survey staff toured the facility with licensed assisted living director (LALD)-A. Survey staff asked LALD-A to initiate a test of the smoke alarms throughout the home. Upon testing, it was found that the smoke alarms in the facility were not interconnected. These deficient conditions were visually verified by LALD-A accompanying on the tour. During an interview on October 1, 2024, at 1:30 p.m., LALD-A stated they understood the smoke alarm requirements.	0 780		

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0 780	Continued From page 5 TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 790		

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0 790	Continued From page 6 On October 1, 2024, at 1:30 p.m., survey staff toured the facility with licensed assisted living director (LALD)-A. The surveyor observed the portable fire extinguishers throughout the facility were not installed on their required wall mount brackets. During an interview on October 1, 2024, at 2:30 p.m., survey staff explained to LALD-A that the portable fire extinguishers must be mounted to ensure all portable extinguishers are readily available, fully charged, and operable at their designated location. LALD-A verified the fire extinguishers were not properly mounted and stated they understood the requirements. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors.	0 800		

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0 800	Continued From page 7 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 October 1, 2024, at 1:30 p.m., survey staff toured the facility with licensed assisted living director (LALD)-A. The surveyor observed the following: GENERAL MAINTENANCE - Electrical outlet covers were missing in resident bedroom 2. - The clothes dryer venting in the mechanical room was disconnected from the dryer allowing lint to collect behind the dryer and not vent to the exterior. - The mechanical room light fixture was missing a light bulb. There was no other artificial light source in the room. - Multiple holes were observed in the closet door for resident bedroom 1. - Throughout the facility it was observed the presence of loose electrical outlets, and electrical outlet covers. - The chain link fence surrounding the property had gates falling off their hinges at multiple locations around the property. During an interview on October 1, 2024, at approximately 1:30 p.m., LALD-A stated they understood the above-listed deficiencies. TIME PERIOD FOR CORRECTION: Seven (7)	0 800		

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0 800	Continued From page 8 days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (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.	0 810		

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0 810	Continued From page 9 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. 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 October 1, 2024, at 1:30 p.m., survey staff toured the facility licensed assisted living director (LALD)-A. The surveyor observed the displayed emergency evacuation floor plans were not accurate. Numbers were posted on all of the resident sleeping room doors. The upper level floor plan did not label resident sleeping rooms 1 and 2. All resident sleeping room numbers are required to be accurately identified on the fire safety and evacuation floor plans to provide efficient communication for exiting in the event of a fire or similar emergency. The emergency evacuation floor plans failed to label the main exit of the facility. The main exit is required to be identified on the plans in order to direct occupants to the exit in the event of an emergency. Additionally, the lower level plans did not identify the office. Fire safety and evacuation floor plans must be correctly labeled to reduce confusion and potential obstructions to egress in a fire or similar	0 810		

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0 810	Continued From page 10 emergency. During an interview on October 1, 2024, at 3:00 p.m., LALD-A verified the FSEP floor plans required revision. On October 1, 2024, at 2:15 p.m., LALD-A provided documentation 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 FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The provided FSEP was from a third-party provider and had not been updated to the specific facility. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. One resident was identified as requiring assistance during an evacuation, but no procedures were included in the plan. During an interview on October 1, 2024, at 3:00 p.m., LALD-A stated they understood the areas of the FSEP that were incomplete and would work on bringing the plan into compliance. TRAINING Record review indicated the licensee failed to	0 810		

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0 810	Continued From page 11 provide training to employees on the FSEP upon hire. During an interview on October 1, 2024, at 3:00 p.m., LALD-A stated employees completed emergency preparedness training using a third-party online training provider at the time of hire and verified this training did not include the facility FSEP. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 820 SS=G	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide a resident bedroom with the minimum window opening meeting the minimum state standard for egress. This affected the occupied resident in bedroom 5 on the lower level.	0 820		

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0 820	Continued From page 12 This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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: On October 1, 2024, at 2:30 p.m., survey staff toured the facility with licensed assisted living director (LALD)-A. During the facility tour, survey staff observed the following items: It was observed that occupied resident bedroom 5 on the lower level did not have window that met the minimum size requirements for egress escape. The clear openable area of the opened window measured 20 inches in wide and 30.75 inches in height, with a total openable area of 615 square inches. The window did not meet the minimum requirements for a total openable area. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. Survey staff explained to LALD-A that at least one egress window in each bedroom must be provided to meet the minimum state standard for an egress window to be a complying bedroom for resident occupancy. LALD-A verbally confirmed the findings. On October 1, 2024, at 2:30 p.m., during the	0 820		

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0 820	Continued From page 13 interview, survey staff explained to LALD-A that an immediate correction order was issued for the above finding. LALD-A acknowledged the above finding. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	0 820		
0 830 SS=F	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to comply with all state and local governing laws, and codes for fire safety, building, and zoning requirements. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On October 1, 2024, at 2:30 p.m., survey staff	0 830		

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0 830	Continued From page 14 toured the facility with licensed assisted living director (LALD)-A. The surveyor observed the lower level of the facility appeared to be newly remodeled. There was a newly constructed wall that was not present on the displayed emergency evacuation floor plans posted in the facility. Survey staff explained to LALD-A that documentation showing the construction was permitted and approved by the authority having jurisdiction would be required to verify the facility complied with all state and local governing laws, and codes for fire safety, building, and zoning requirements. During an interview on October 1, 2024, at 2:30 p.m., LALD-A stated they did not know when the office wall was constructed. No further information was provided by LALD-A at the time of survey. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 830		
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 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.	01760		

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01760	Continued From page 15 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered as prescribed and administered per the manufacturer's instructions for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During entrance conference on October 1, 2024, at 11:32 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated the licensee provided medication services to the licensee's residents. R2's diagnosis included diabetes and diabetic ketoacidosis (life-threatening complication of diabetes in which acid builds up in the blood). R2's Service Plan dated, August 22, 2024, indicated R2 received medication administration services. R2's 90-Day Assessment dated September 24, 2024, indicated R2 dialed own insulin dose, staff verified correct dosage and R2 self-administered insulin. R2's Individual Medication Management Plan	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36754	A. BUILDING: _____ B. WING _____	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST GROUP HOME LLC	4232 5TH STREET NE COLUMBIA HEIGHTS, MN 55421

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01760	Continued From page 16 dated August 22, 2024, indicted R2 was capable of administering own insulin and staff were to supervise dose. R2's prescriber orders dated June 17, 2024, included the following insulin orders: -Lantus Solostar (long-acting) insulin pen 16 units daily; -Humalog Kwikpen (rapid-acting) insulin four units three times a day with meals along with sliding scale coverage for blood sugars levels of: -150-100 add one unit of insulin -201-250 add two units of insulin -251-300 add three units of insulin -301-35 add four units of insulin -351-400 add five units of insulin -over 400 add six units of insulin; and -ok to self-administer insulin with staff supervising dose. R2's September and October 2024 Medication Administration Summary indicated R2 was scheduled and received Novolog and Humalog insulin as noted above and R2 was to self-inject insulins and staff were to observe. On October 2, 2024, at 8:11 a.m., the surveyor observed unlicensed personnel (ULP)-C observe R2 monitor his blood glucose with a freestyle Libre device (electronic continuous monitor) and record R2's blood glucose results of 284 milligrams per deciliter (mg/dl) in Rtasks (electronic charting program). ULP-C stated R2 would receive an additional three units of Humalog sliding scale insulin for a total of seven units. ULP-C gathered R2's prefilled insulin pens, entered R2 room and handed R2 Lantus insulin pen. R2 dialed an undetermined insulin dose and self-injected into left lower abdomen. ULP-C handed R2 his Humalog insulin pen. R2 dialed	01760		

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01760	Continued From page 17 an undetermined dose of Humalog insulin and self-injected into left lower abdomen. R2 did not prime either insulin pens two units prior to dialing prescribed insulin dose and self-administering. ULP-C did not remind R2 to prime insulin pen two units or remind R2 to add additional three units of Humalog insulin for sliding scale dose. In addition, ULP-C was not observed to verify insulin doses prior R2 self-administering insulins to ensure correct dosages. Immediately following insulin administration, ULP-C documented R2's insulin was administration as ordered in Rtasks. On October 2, 2024, at 8:24 a.m., ULP-C confirmed she did verify R2's insulin doses prior to R2 self-administering as directed. The surveyor asked ULP-C how did R2 know what dose of sliding scale Humalog insulin R2 should receive. ULP-C stated R2 was familiar with his insulin orders and ULP-C stated she "thinks" R2 dialed a total of eight units of Humalog insulin instead of seven. ULP-C reviewed R2's electronic records and confirmed R2 should have received a total of seven units of Humalog insulin instead of eight. ULP-C stated R2 does what he wants to do and if someone tells him differently R2 would get upset. ULP-C's employee record indicated ULP-C passed a skill and competency for insulin administration on July 10, 2023. On October 2, 2024, at 12:30 p.m., LALD-A stated R2's provider wrote an order for R2 to self-administer own insulin. LALD-A stated R2 was sometimes non-compliant with his medications and the nurse would provide education to R2. LALD-A reviewed R2's medication administration summary and assessment and stated staff were directed to	01760		

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01760	Continued From page 18 observe R2's insulin dosage and administer of insulin. The licensee's Delegation of Assisted Living Tasks policy dated July 15, 2025, indicated the clinician may delegate procedures according to the following: -the clinician instructed the home health aide in the proper methods to perform the procedure with respect to each resident; -the clinician provided the home health aide with written instructions specific to the resident; and -the home health aide demonstrated to the clinician competence in the procedure. The licensee's Verbal Reminders for Medications, Treatments and Exercises policy dated July 15, 2024, indicated "reminder "means providing verbal or visual reminder to the resident to take regular scheduled medication or to perform regularly scheduled treatments or exercises. Related to medications, verbal reminders include providing a verbal or visual reminder to the resident to take regularly scheduled medications which includes bringing the resident previously set-up medication, medication in original containers or liquid or food to accompany the medication. The manufacturer's instructions for Lantus Solostar insulin pen dated June 2022, indicated to dial insulin pen two units, press the inject button before dialing insulin dose. The manufacturer's instructions for Humalog Kwikpen insulin pen dated 2023, indicated priming insulin pen two units to ensure accurate dose. No further information was provided.	01760		

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01760	Continued From page 19 TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a resident treatment plan was followed and any follow up procedure was provided to meet the resident's needs for one of one resident (R2) who received blood glucose monitoring. 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:	01960		

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01960	Continued From page 20 During entrance conference on October 1, 2024, at 11:32 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated the licensee provided treatment and therapy services to the licensee's residents to include blood glucose monitoring. R2's diagnosis included diabetes and diabetic ketoacidosis (life-threatening complication of diabetes in which acid builds up in the blood). R2's Service Plan dated August 22, 2024, indicated R2 received blood glucose monitoring three times a day. On October 2, 2024, at 8:11 a.m., the surveyor observed unlicensed personnel (ULP)-C observe R2 monitor his blood glucose with a freestyle Libre device (electronic continuous monitor) and record R2's blood glucose results of 284 milligrams per deciliter (mg/dl) in Rtasks (electronic charting program). R2's 90-Day Assessment dated September 24, 2024, indicted R2 checked his own blood glucose and staff were to document results. R2's Individualized Treatment and Therapy Plan dated August 22, 2024, indicated R2 was to monitor his blood glucose three times a day and record results. Notify the registered nurse (RN) if R2's blood glucose was less than 70 or greater than 300. R2's vital signs report from September 2, 2024, to October 2, 2024, indicated: -On September 2, 2024, at 8:00 a.m., blood glucose result of 351; -On September 4, 2024, at 8:00 a.m., blood	01960		

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01960	Continued From page 21 glucose result of 318; -On September 6, 2024, at 6:00 p.m., blood glucose result of 400; -On September 7, 2024, at 8:00 a.m., blood glucose result of 400; -On September 7, 2024, at 6:00 p.m., blood glucose result of 400; -On September 8, 2024, at 8:00 a.m., blood glucose result of 318; -On September 10, 2024, at 8:00 a.m., blood glucose result of 350; -On September 11, 2024, at 8:00 a.m., blood glucose result of 400; -On September 13, 2024, at 8:00 a.m., blood glucose result of 400; -On September 14, 2024, at 8:00 a.m., blood glucose result of 320; -On September 15, 2024, at 1:00 p.m., blood glucose result of 355; -On September 17, 2024, at 8:00 a.m., blood glucose result of 400; -On September 25, 2024, at 1:00 p.m., blood glucose result of 400; and -On September 27, 2024, at 8:00 a.m., blood glucose result of 61. R2's resident notes from August 1, 2024, through October 2, 2024, lacked documentation the RN had been notified of the above noted out of range blood glucose readings; furthermore, R2's record lacked documentation any follow up treatment or procedure was provided. On September 2, 2024, at 11:40 a.m., ULP-C stated R2's record indicated the RN was to be notified if R2's blood glucose was below 70 or above 300. ULP-C stated documentation should be completed in R2's electronic record in Rtasks, indicating the RN had been notified with any directions given by the RN. ULP-C stated she	01960		

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01960	Continued From page 22 would notify the RN if R2's blood glucose was out of parameters; however, did not document the call in R2's record. On September 2, 2024, 12:30 p.m., LALD-A reviewed R2's blood glucose readings and progress notes for September 2024, and verified several of R2's blood glucose parameters were above 300, and no documentation was noted in R2's record the RN had been notified as directed. LALD-A stated she believed staff notified the RN; however, did not document the event in R2's record. The Treatment and Therapy Management policy dated July 15, 2024, indicated the RN or licensed professional would prepare and individualized treatment or therapy management plan for each resident receiving ordered or prescribed treatments or therapy services, which addressed procedures for notifying the RN or licensed health professional when a problem arises related to the treatment or therapy services. Each staff member who administers a treatment or therapy is responsible for documenting this in the clinical record. The Clinical Records policy dated July 15, 2025, indicated documentation of incidents and/or 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 professional. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		

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

Type: Full
Date: *10/02/24*
Time: 11:00:00
Report: 1025241194

Food and Beverage Establishment Inspection Report

Location:
Midwest Group Home Llc
4232 5th Street Ne
Columbia Heights, MN55421
Anoka County, 02

Establishment Info:
ID #: 0037477
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 6125323780
ID #:

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

No NEW orders were issued during this inspection.

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

Pest control service arrived at facility during inspection for routine exterior treatment
Recommend replacing cabinet hardware with hardware that is smooth to the touch (current hardware has decorative flourishes and a hollow back where dirt can build up and become difficult to clean)
Recommend storage containers for opened dry items in the corner cabinet
Clean the interior of the corner cabinets
Discussed one resident prepares their own food with minimal supervision, difference between same day TCS service for residents vs personal items prepared by residents
Food thermometer and irreversible TMD strip for dishwasher (orange) available

FACILITY
Appliances are residential
Vinyl flooring, solid surface countertops, tile backsplash

SINK USAGE
Facility has a two (2) compartment sink
Facility has a dishwasher with a sanitize cycle
Facility does not have a 3 compartment sink
Facility does not have a dedicated food preparation sink

COUNTERTOPS AND FOOD CONTACT SURFACES
Provide a smooth, non-porous food contact surface (e.g. cutting boards) that can be easily washed, rinsed, and sanitized (e.g. run through the dishwasher). Soap and water can be used to clean non-food contact surfaces. By provided a cutting board or other non-porous food contact surface, the countertops can be kept clean without the use of substances which may damage the finish. Do not use wood as a food contact surface.

DISHWASHING – NSF 184
Dishwasher has a sanitizing rinse option (NSF/ANSI Standard 184) – use this option to sanitize utensils
Provide a means of testing the internal contact temperature of utensil in the dishwasher
If the sanitize cycle on the dishwasher will not be used, provide an alternate means of chemical sanitizing (e.g. a bus tub or other basin, to be filled with water and sanitizing solution e.g. chlorine bleach (non-scented, labeled for Sanitizing Food Contact Surfaces) at 50-100 PPM; provide a test kit for chemical sanitizing)
Recommend having an alternative means of sanitizing available case of emergency or service interruption

EQUIPMENT
MN 4626.0506 includes alternate equipment and finish requirements for adult care facilities which serve TCS foods for same-day service only:

MN 4626.0506 G. A food establishment that is an adult care center, child care center, or boarding establishment does not need to comply with item A [certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program for food service equipment] if approved by the regulatory authority and the food establishment:
(1) serves only non-TCS food; or
(2) prepares TCS foods only for same-day service.

Discontinue any service of TCS food for multiple day service (e.g. cooling and reservice of leftovers of prepared and cooked TCS food), or upgrade finishes and equipment in the kitchen

GENERAL COMMENTS
CFPM (Certified Food Protection Manager)
For information, please search "MDH CFPM"

Discussed employee health and hygiene, exclusion for individuals from the kitchen with vomiting and/or diarrheal illness, sore throat with fever, or reportable illness; food cooking and holding temperatures, cross-contamination, allergens, food storage order in refrigerator, separating resident food from medication or staff food, avoiding bare hand contact with foods which will not be cooked (cut fruit, deli sandwiches), chemical label, use, and storage, pest control, quarantine meals

Date marking TCS foods (when packages are opened or food is prepared, date mark and discard after 7 days, except for certain cultured dairy products)
Discussed food source, recalls, and refusing food which has signs of tampering or temperature abuse
Information on food recalls available "MDA Food Recall"
https://www.mda.state.mn.us/food-feed/food-recalls-consumer-advisories-minnesota

FACT SHEETS
Please search "MDH Fact Sheets" for the Food Business fact sheets page
"Cleaning and Sanitizing" https://www.health.state.mn.us/communities/environment/food/docs/fs/cleansanfs.pdf
"Food Cooking Temperatures"
https://www.health.state.mn.us/communities/environment/food/docs/fs/timetempfs.pdf
"Date Marking TCS foods"
https://www.health.state.mn.us/communities/environment/food/docs/fs/datemarkingfs.pdf

Food and Beverage Establishment Inspection Report

"Highly Susceptible Populations" - no service or raw or undercooked animal food, use Pasteurized eggs when preparing eggs raw or undercooked or batching scrambled eggs
https://www.health.state.mn.us/communities/environment/food/docs/fs/highsuspopfs.pdf

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 1025241194 of 10/02/24.

Certified Food Protection Manager: Fahima Mahamud

Certification Number: FM100924 Expires: 10/01/25

Inspection report reviewed with person in charge and emailed.

Signed:_____
Establishment Representative

Signed: Casey Kipping
Casey Kipping
Public Health Sanitarian III
Freeman Building St Paul
651-201-4513
casey.kipping@state.mn.us