Electronically Delivered

June 25, 2025

Licensee
Covenant Living Of Golden Valley Assisted Living Memory
5825 St. Croix Avenue North
Golden Valley, MN 55422

RE: Project Number(s) SL30433016

Dear Licensee:

On May 7, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on February 20, 2025. 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,

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

JMD

Electronically Delivered

March 26, 2025

Licensee
Covenant Living of Golden Valley Assisted Living Memory Care
5825 St. Croix Avenue North
Golden Valley, MN 55422

RE: Project Number(s) SL30433016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 20, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

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

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

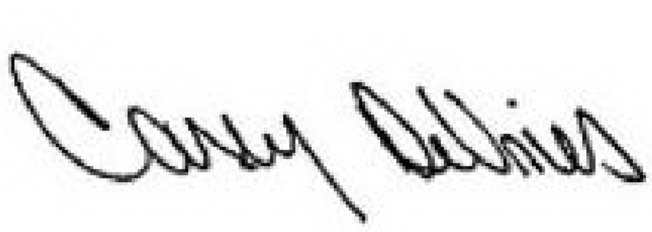
the website listed above.

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

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

If you have any questions, please contact me.

Sincerely,



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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30433	A. BUILDING: _____ B. WING _____	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT LIVING OF GOLDEN VALLEY ASSI	5825 ST. CROIX AVENUE NORTH GOLDEN VALLEY, MN 55422

(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 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: SL30433016-0 On February 18, 2025, through February 20, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 11 residents; 11 receiving services under the Assisted Living Facility with Dementia Care license. An immediate correction order was identified on February 18, 2025, issued for SL30433016-0, tag identification 1290. During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain 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.	
0 220 SS=C	144G.17 LICENSE RENEWAL A license that is not a provisional license may be	0 220		

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0 220	Continued From page 1 renewed for a period of up to one year if the licensee: (1) submits an application for renewal in the format provided by the commissioner at least 60 calendar days before expiration of the license; (2) submits the renewal fee under section 144G.12, subdivision 3; (3) submits the late fee under section 144G.12, subdivision 4, if the renewal application is received less than 30 days before the expiration date of the license or after the expiration of the license; (4) provides information sufficient to show that the applicant meets the requirements of licensure, including items required under section 144G.12, subdivision 1; (5) provides information sufficient to show the licensee provided assisted living services to at least one resident during the immediately preceding license year and at the assisted living facility listed on the license; and (6) provides any other information deemed necessary by the commissioner. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide information sufficient to show that the applicant met the requirements of licensure, including items required under section 144G.12, subdivision 1; which required documentation of compliance with the background study requirements in section 144G.13 for the owner, controlling individuals, and managerial officials. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than	0 220		

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0 220	Continued From page 2 a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living license effective January 1, 2025, through December 31, 2025. On February 18, 2025, at 10:35 a.m., during the facility tour, the surveyor observed the licensee's posted license which had expired on December 31, 2024. Licensed assisted living director/clinical nurse supervisor (LALD/CNS)-D stated the Minnesota Department of Health (MDH) would not issue them a copy of their current license because the licensee's Chief Executive Officer (CEO) did not want to get fingerprinted and had not had a background study completed. LALD/CNS-D stated the CEO did not understand why they needed to get fingerprinted since they were never at the facility; they stated the CEO lived out-of-state. LALD/CNS-A stated they had been working with the department of human services (DHS) to get the CEO fingerprinted. On February 20, 2025, at 3:51 p.m., MDH licensing software indicated the above-mentioned license was still pending issuance. The facility was still in good standing per the licensing division, however, a current license would not be issued until the CEO of the licensee was fingerprinted and had a background study completed. No further information was provided.	0 220		

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0 220	Continued From page 3 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 220		
0 340 SS=F	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or staff of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must: (1) document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and execute a plan of correction (POC) for 144G.62 Subd. 4., registered nurse (RN) 30-day supervision and	0 340		

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0 340	Continued From page 4 144G.82 Subd. 3., dementia policies, issued during their previous routine survey. 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 5-6, 2022, the Minnesota Department of Health (MDH) conducted a routine survey and issued citations for RN 30-day supervision of unlicensed personnel (ULP) and dementia policies. SUPERVISION OF ULP ULP-B ULP-B was hired on March 14, 2022, to provide direct cares to residents. ULP-B's employee record lacked evidence a RN 30-day supervision was completed. ULP-L ULP-L was hired on March 20, 2023, to provide direct cares to residents. ULP-L's employee record lacked evidence a RN 30-day supervision was completed. DEMENTIA CARE POLICIES On February 19, 2025, at 2:44 p.m., licensed assisted living director/clinical nurse supervisor	0 340		

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0 340	Continued From page 5 (LALD/CNS)-D and associate executive director (AED)-N stated they did not have documentation residents, or resident's representatives, were provided the required dementia policies for R2 or R3. AED-N provided their dementia policies and stated, "they could use some bulking up, but they are there." On February 19, 2025, at 2:56 p.m., LALD/CNS-D stated the required dementia policies were not provided to any of their residents or representatives. The surveyor reviewed the licensee's POC from the previous survey on July 5-6, 2022, for RN 30-day supervision of ULPs and required dementia policies. LALD/CNS-D stated their POC for the RN 30-day supervision was incomplete and provided two Unlicensed Staff Observation forms for ULP-H (who was included in the citation from the previous survey) dated May 11, 2020, and November 16, 2020. The forms were completed prior to the previous survey; LALD/CNS-D stated they must have found ULP-H's RN 30-day supervisions forms completed prior to the previous survey. LALD/CNS-D stated they did not perform an audit of all other ULP records to ensure a RN 30-day supervision was completed. LALD/CNS-D stated their POC for dementia policies was incomplete as well and provided an Assisted Living with Memory Care Disclosure Form which lacked all of the required dementia care policies. The licensee lacked a written POC for both citations. On February 20, 2025, at 11:04 a.m., LALD/CNS-D stated since they did not audit their ULP's records for RN 30-day supervisions after receiving a citation on their previous survey, and they could not be sure if all of their ULPs had an RN supervision since they were hired.	0 340		

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0 340	Continued From page 6 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage;	0 480		

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

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0 480	Continued From page 8 Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated February 18, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee on February 18, 2025. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 650 SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced	0 650		

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0 650	Continued From page 9 by: Based on observation, interview, and record review, the licensee failed to ensure employee records contained required content to include orientation, tuberculosis (TB) and annual training documentation for one of two employees (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-B ULP-B was hired on March 14, 2022, to provide direct cares to residents. ULP-B's employee record lacked evidence of the following required orientation topics: -overview of assisted living statutes; -review of provider policies and procedures; -assisted living bill of rights; -handling resident complaints, reporting complaints, where to report; -consumer advocacy services; and -principles of person-centered planning/service delivery. ULP-B's employee record lacked evidence of the following required annual training topics: -assisted living bill of rights; -review of provider policies and procedures; -principles of person-centered planning/service delivery; and	0 650		

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0 650	Continued From page 10 -hearing loss training. ULP-B's employee record lacked evidence of initial and annual tuberculosis (TB) training. On February 19, 2024, at 8:00 a.m., the surveyor observed ULP-B administer medication to three residents. ULP-B stated they completed the above-mentioned trainings. On February 20, 2025, at 11:04 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-D stated it was a combination of human resources (HR) and themself (LALD/CNS-D) who were providing ULP training. LALD/CNS-D stated they knew ULP-B completed their orientation, annual training and TB training but could not find the documentation. The licensee's Training Documentation policy, undated, indicated, "Staff training will be documented completely and correctly." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must	0 660		

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0 660	Continued From page 11 include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a tuberculosis (TB) chest X-ray (CXR) was accompanied by a positive TB Mantoux (skin test) or blood test completed within 90 days prior to the CXR for two of two employees (unlicensed personnel (ULP)-B, ULP-L). 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: The licensee's TB risk assessment was completed on May 14, 2024. The licensee was at a low risk level. ULP-B ULP-B was hired on March 14, 2022, to provide direct cares to residents. ULP-B's employee record included a Baseline TB Screening Tool for Health Care Workers form	0 660		

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0 660	Continued From page 12 which indicated ULP-B had a positive reaction to a TB skin test or TB blood test in 2022. ULP-B's employee record included a Radiology Report with a CXR result dated October 27, 2021, which indicated the CXR showed, "no radiographic evidence of active tubercular disease." ULP-B's employee record lacked documentation of a positive TB Gold (blood test) or Mantoux (skin test) completed within 90 days prior to the CXR. ULP-L ULP-L was hired on March 20, 2023, to provide direct cares to residents. ULP-L's employee record included a Baseline TB Screening Tool for Health Care Workers form which indicated ULP-L did not have a history of a positive reaction to a TB skin test or TB blood test. ULP-L's employee record included a Professional Portable X-Ray with a CXR result dated March 25, 2023, which indicated the CXR showed, "no radiographic evidence for active TB." ULP-B's employee record lacked documentation of a positive TB Gold (blood test) or Mantoux (skin test) completed within 90 days prior to the CXR. The Minnesota Department of Health TB FAQ, last updated on December 13, 2024, indicated if the health care worker had a prior positive TB test result, and they only have the CXR but no other test documentation, then they need to take a new TB test. If the result is positive, a new CXR needs to be completed. The CXR needs to be done within 90 days of the positive test date or dated any time after the positive test date.	0 660		

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0 660	Continued From page 13 The licensee's TB Prevention and Control policy, undated, indicated: "Staff Screening & Testing: staff refers to all paid employees, unpaid employees, contractors, students, and regularly scheduled volunteers. a. Upon hire staff will be screened for TB symptoms and tested for TB. Staff will not work in resident care areas or areas where there is potential contact or shared space with residents until TB testing and screening is completed and a negative TB test is provided. i. If the first step of the two-step TST is negative the employee may begin working with residents (if the TST is dated within 90 days before hire) but must have the second TST test within 21 days after hire. b. Upon hire all staff are screened for active signs of TB using the Baseline TB Screening Tool provided by the MN Department of Health or a similar tool with all required information. c. Upon hire all staff are tested for tuberculosis with either a two-step Mantoux or an IGRA laboratory blood test. The results of the TB test will be recorded and kept in the employee's medical file. i. If a staff member presents a two-step Mantoux with negative results or a negative IGRA test within 90-days of hire, this will be used for proof of negative result and the staff member does not need further testing. ii. If a staff member has the second step of a Mantoux test and a negative result within 12 months before hire, the staff member only needs to complete the 2nd step Mantoux with a negative result to satisfy proof of negative Mantoux test. iii. Two-step TST: Will be completed at facility. Step 1: inject tuberculin purified protein derivative (PPD), per provider directions, into the inner surface of the forearm, wait for 48 to 72	0 660		

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0 660	Continued From page 14 hours, and have the skin test reaction read. Indeterminate or borderline results indicate an uncertain likelihood of M. tuberculosis infection and should be further evaluated by a physician. c. TST results are documented by millimeters (mm) of induration and interpreted as 'positive' or 'negative'. i. All TST results measuring 0-4mm of induration are considered negative. ii. TST results between 5-9mm of induration are considered negative for most HCWs but is positive for persons with certain risk factors, including: -HIV positive -Recent close contact with someone with infectious TB disease -Organ transplant recipient -immunosuppressed due to taking immunosuppressive drugs or TNF alpha inhibitor drugs -Have a current CXR that shows 'scarring' or 'fibrosis' or 'old, healed TB' iii. TST results >9mm of induration are considered positive HCWs who are vaccinated with BCG will not be exempted from TST testing unless they have a documented positive result from a prior test and a negative chest x-ray. Disregard BCG history when interpreting TST results." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident:	0 730		

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0 730	Continued From page 15 (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service	0 730		

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0 730	Continued From page 16 termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure resident records included a discharge summary for two of two residents (R1, 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) 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: R1 R1 was admitted to the licensee on March 22, 2021, and discharged on January 15, 2025. R1's record included an after visit summary (AVS), dated January 14, 2025, completed by a certified nurse practitioner (CNP) who was not employed by the licensee. R3 R3 was admitted to the licensee on June 5, 2024, and discharged on October 13, 2024. R3's record included an AVS, dated September 12, 2024, completed by a CNP who was not employed by the licensee.	0 730		

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0 730	Continued From page 17 On February 19, 2025, at 1:20 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-D stated they only had the CNP's discharge paperwork from the from January 14, 2025, for R1. LALD/CNS-D stated R1 moved from their skilled nursing facility (SNF) located in the same building; they stated since R1 was transferred within their organization they did not think a discharge summary was required. On February 19, 2025, at 1:38 p.m., LALD/CNS-D stated R3's discharge summary dated September 12, 2024, was completed while the resident was at another care facility. LALD/CNS-D stated R3 left the facility on September 18, 2024 and did not have a completed discharge summarycompleted by the licensee. The licensee's Discharge Summary policy, undated, indicated: "1. A discharge summary will be written by the time of discharge. 2. The facility will provide the resident with a written discharge summary at the time of discharge. 3. If the resident consents, the facility will provide the resident's representative and case manager a written discharge summary at the time of discharge. 4. The discharge summary will include, if applicable, a. Summary of the resident's stay, including i. Diagnosis ii. Courses of illnesses iii. Allergies iv. Treatments v. Therapies vi. Pertinent lab results	0 730		

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0 730	Continued From page 18 vii. Pertinent radiology results viii. Pertinent consultation results ix. Final summary of the resident's status. The summary will be based upon the latest assessment or review and, if applicable, will include resident status including baseline and current mental, behavioral and functional status. b. Reconciliation of all predischarge medications with post discharge prescribed and over-the-counter medications c. Post discharge plan developed with the resident, and if the resident consents, resident's representatives. d. The post discharge plan will include: i. Resident's planned residence ii. Arrangements made for follow-up care iii. Needed post discharge medical and nonmedical services 5. The discharge summary may be developed by the RN, LALD, or designee appropriate to information required in the discharge summary based upon the individual resident and the services they received during their stay." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
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;	0 810		

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0 810	Continued From page 19 (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training. 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	0 810		

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0 810	Continued From page 20 or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On February 19, 2025 at approximately 2:30 p.m., Maintenance Manager (M)-M provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP failed to include the following: The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. On February 19, 2025, M-M stated they understood the area in the policy that was incomplete and would work to get their policy into compliance. TRAINING: The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. The licensee's training records indicated staff were trained upon hire but failed to provide training to employees on the FSEP twice	0 810		

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0 810	Continued From page 21 per year. No other training documentation was provided. On February 19, 2025, M-M stated they understood the requirements for training staff, and would implement a training program that was compliant. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure they received a background study (BGS) clearance from NETStudy 2.0 (web-based system use to submit BGS requests to the Department of Human Services (DHS)) in affiliation with the assisted	01290		

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01290	Continued From page 22 living licensee's health facility identification number (HFID) for two of 13 employees (unlicensed personnel (ULP-I, ULP-J). Further, the licensee failed to re-run a COVID-19 expired BGS for three of 13 employees (ULP- G, ULP-H, activities (A)-F). 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's HFID was 30433. ULP-G ULP-G was hired on June 22, 2009, to provide direct cares to residents. The licensee's Employee List dated February 18, 2025, indicated ULP-G was a current employee for the licensee. The licensee's NETStudy 2.0 report completed on February 18, 2025, indicated ULP-G had a COVID expired BGS. ULP-H ULP-H was hired on March 26, 2018, to provide direct cares to residents. The licensee's Employee List dated February 18, 2025, indicated ULP-H was a current employee for the licensee.	01290		

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01290	Continued From page 23 The licensee's NETStudy 2.0 report completed on February 18, 2025, indicated ULP-H had a COVID expired BGS. ULP-I ULP-I was hired on April 30, 2017, to provide direct cares to residents. The licensee's Employee List dated February 18, 2025, indicated ULP-I was a current employee for the licensee. The licensee's NETStudy 2.0 report completed on February 18, 2025, indicated ULP-I did not have a completed BGS. ULP-J ULP-J was hired on March 23, 2015, to provide direct cares to residents. The licensee's Employee List dated February 18, 2025, indicated ULP- J was a current employee for the licensee. The licensee's NETStudy 2.0 report completed on February 18, 2025, indicated ULP-H did not have a completed BGS. A-F A-F was hired on April 12, 2011, to assist residents with activities. The licensee's Employee List dated February 18, 2025, indicated A-F was a current employee for the licensee. The licensee's NETStudy 2.0 report completed on February 18, 2025, indicated A-F had a COVID expired BGS.	01290		

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01290	Continued From page 24 On February 18, 2025, at 10:35 a.m., the surveyor observed A-F lead morning activities unsupervised with residents. On February 18, 2025, at 11:39 a.m., the surveyor observed the licensee's NETStudy 2.0 for HFID 30433 with human resources director (HRD)-C who stated it was their responsibility to run a BGS for employees until human resources assistant (HRA)-K was hired in November 2024. HRD-C stated they were aware COVID expired BGS were required to be reprocessed. HRD-C stated COVID expired BGS needed to be reprocessed for over 100 staff members between all of their facilities which included another assisted living facility (ALF) and a skilled nursing facility (SNF). HRD-C stated the staff members must have been overlooked. HRD-C stated ULP-I had worked for the facility at one time, quit, and was then rehired but a BGS could not be found in NETStudy 2.0. HRD-C stated they would begin immediately to complete BGS immediately. On February 18, 2025, at 12:24 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-D stated employee BGS were completed by HRD-C and HRD-K. On February 18, 2025, at 1:35 p.m., HRD-C stated they sent A-F home as they needed to be fingerprinted before a BGS could be completed. HRD-C stated they reach out to ULP-G and ULP-I to let them know they needed to be fingerprinted before a BGS could be completed. The DHS website for Background Studies updated February 18, 2025, indicated, "The Minnesota Department of Human Services (DHS) requires background studies for people who work	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30433	A. BUILDING: _____ B. WING _____	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT LIVING OF GOLDEN VALLEY ASSI	5825 ST. CROIX AVENUE NORTH GOLDEN VALLEY, MN 55422

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01290	Continued From page 25 in certain health and human services programs, and in childcare settings if they provide care or have direct contact with vulnerable populations. DHS also completes background studies on others, such as people planning to provide foster care or adopt. Minnesota statutes direct the background study process for entities required to initiate background studies." It further indicated, "DHS temporarily modified background studies during the COVID-19 pandemic. Those modifications ended Jan. 1, 2023. Learn more about the return to fully compliant studies." The licensee's Background Checks policy, undated, indicated, "All employees; as well as contractors, and regularly scheduled volunteers of the facility with direct resident contact will undergo a background study through OHS. Only those with satisfactory results will continue to work with the facility and its residents." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered	01440		

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	30433	A. BUILDING: _____ B. WING _____	02/20/2025

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01440	Continued From page 26 nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for two of two employees (unlicensed personnel (ULP)-B, ULP-L). 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: ULP-B ULP-B was hired on March 14, 2022, to provide direct cares to residents. ULP-B's employee record lacked evidence a RN 30-day supervision was completed.	01440		

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01440	Continued From page 27 ULP-L ULP-L was hired on March 20, 2023, to provide direct cares to residents. ULP-L's employee record lacked evidence a RN 30-day supervision was completed. On February 19, 2025, at 8:00 a.m., the surveyor observed ULP-B administer medications to three residents. ULP-B stated they were unsure if they had a RN 30-day supervision. On February 19, 2025, at 2:56 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-D stated they were unable to locate RN 30-day supervisions for ULP-B or ULP-L. On February 20, 2025, at 11:04 a.m., LALD/CNS-D stated since they did not audit their ULP's records for RN 30-day supervisions after receiving a citation on their previous survey; they could not be sure if all of their ULPs had an RN supervision since they were hired. The licensee's Supervision of Unlicensed Personnel policy, undated, indicated, "Supervision of Unlicensed Staff Performing Services that are not Delegated by an RN or Licensed Health Professional. The RN or LALD will identify who will supervise unlicensed persons that provide services that are not delegated by an RN or a licensed health professional, such as housekeeping and laundry or other tasks defined as supportive services. These persons will be directly supervised within 30 days of beginning work and thereafter based on performance." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	01440		

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	30433	A. BUILDING: _____ B. WING _____	02/20/2025

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01440	Continued From page 28 (21) days	01440		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of	02110		

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02110	Continued From page 29 move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop the required ten dementia care policies. Further, the licensee failed to ensure policies and procedures for assisted living with dementia care (ALFDC) were provided to residents and the residents' legal and designated representatives at the time of move in for one of one dementia care resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R2 R2 was admitted to the licensee on February 14, 2024. The entire facility was a secured memory care unit. R2's records lacked evidence the licensee provided the resident, or residents' designated representative, with the following ten required policies and procedures for the ALFDC license: - philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; - evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are	02110		

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02110	Continued From page 30 person-centered and evidence-informed; - wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; - medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; - staff training specific to dementia care; - description of life enrichment programs and how activities are implemented; - description of family support programs and efforts to keep the family engaged; - limiting the use of public address and intercom systems for emergencies and evacuation drills only; - transportation coordination and assistance to and from outside medical appointments; and - safekeeping of residents' possessions. The licensee lacked the following ten required policies and procedures for the ALFDC license: - evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; - wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; - medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; - limiting the use of public address and intercom systems for emergencies and evacuation drills only; - transportation coordination and assistance to and from outside medical appointments; and - safekeeping of residents' possessions.	02110		

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02110	Continued From page 31 On February 19, 2025, at 2:44 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-D and associate executive director (AED)-N stated they did not have documentation the required dementia policies were provided for any of their residents or representatives. AED-N provided their dementia policies and stated, "they could use some bulking up, but they are there." On February 19, 2025, at 2:56 p.m., LALD/CNS-D stated the required dementia policies were not provided to any of their residents or representatives. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		

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

Type: Full
Date: *02/18/25*
Time: 11:30:00
Report: 1043251049

Food and Beverage Establishment Inspection Report

Location:
Clgv Assisted Living Memory
5825 St. Croix Avenue North
Golden Valley, MN55422
Hennepin County, 27

Establishment Info:
ID #: 0037914
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7637321434
ID #:

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

The following orders were issued during this inspection.

3-500E Microbial Control: time as a control

3-501.19A ***** Priority 2 *****

MN Rule 4626.0408A Develop written procedures prior to using time as a public health control for time/temperature control for safety food and maintain the procedures in the food establishment.

FACILITY USES TIME AS A PUBLIC HEALTH CONTROL FOR MILK. ADVISED STAFF TO TIME STAMP AND DISCARD LEFTOVERS AFTER SERVICE. FORM & FACT SHEET PROVIDED WITH REPORT. COMPLY WITH ABOVE RULE.

Comply By: 02/18/25

5-200A Plumbing: approved materials/design

5-202.12A ***** Priority 2 *****

MN Rule 4626.1050A Provide a handwashing sink equipped with running water at a temperature to permit handwashing for at least 15 seconds through a mixing valve or combination faucet.

REPEAT FROM 7/5/22. FIRESIDE FOOD SERVICE AREA DOES NOT HAVE A HANDWASHING SINK PRESENT - STAFF MUST PASS THROUGH KITCHEN DOORS FOR NEAREST HANDWASHING SINK. ADVISED STAFF TO PROVIDE HANDWASHING SINK FOR THIS AREA. COMPLY WITH ABOVE RULE.

Comply By: 08/18/25

4-400 Equipment Location and Installation

4-402.11A

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

MISSING/FAILED CAULKING OBSERVED ALONG DISH MACHINE TABLE. ADVISED STAFF TO REMOVE EXISTING CAULK AND RE-SEAL EQUIPMENT TO THE WALL. COMPLY WITH

ABOVE RULE.
Comply By: 02/18/25

5-200A Plumbing: approved materials/design

5-201.11B

MN Rule 4626.1040B Maintain the plumbing system in good repair.

WATER LEAKING FROM 3 COMP SINK FAUCETS. ADVISED STAFF TO REPAIR PLUMBING. COMPLY WITH ABOVE RULE.
Comply By: 02/18/25

6-100 Physical Facility Construction Materials

6-101.11A1

MN Rule 4626.1325A1 Provide smooth, durable, and easily cleanable floor, wall and ceiling surfaces.

REPEAT FROM 7/5/22. BASE COVING FOR PREP ROOM CONNECTED TO ASSISTED LIVING MEMORY DINING ROOM WAS INSTALLED INCORRECTLY ON TOP OF THE FLOOR TILES. ADVISED STAFF TO REPAIR. ILLUSTRATION PROVIDED WITH REPORT. COMPLY WITH ABOVE RULE.
Comply By: 08/18/25

Surface and Equipment Sanitizers

S/S LACTIC ACID: = 1875 PPM at Degrees Fahrenheit
Location: SANI BUCKET
Violation Issued: No

S/S LACTIC ACID: = 1875 PPM at Degrees Fahrenheit
Location: SAN DISPENSER
Violation Issued: No

HOT WATER: = at 160 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: HAM
Temperature: 145 Degrees Fahrenheit - Location: FIRESIDE SERVING LINE
Violation Issued: No

Process/Item: MASHED POTATO
Temperature: 147 Degrees Fahrenheit - Location: FIRESIDE SERVING LINE
Violation Issued: No

Process/Item: PASTA
Temperature: 150 Degrees Fahrenheit - Location: FIRESIDE SERVING LINE
Violation Issued: No

Process/Item: SOUP
Temperature: 167 Degrees Fahrenheit - Location: HOT BOX
Violation Issued: No

Process/Item: CABBAGE
Temperature: 41 Degrees Fahrenheit - Location: REACH IN COOLER - SIDE PREP AREA
Violation Issued: No

Process/Item: LETTUCE
Temperature: 41 Degrees Fahrenheit - Location: REACH IN COOLER - SIDE PREP AREA
Violation Issued: No

Process/Item: HARD BOILED EGG
Temperature: 41 Degrees Fahrenheit - Location: REACH IN COOLER - COOK LINE
Violation Issued: No

Process/Item: HOT DOG
Temperature: 41 Degrees Fahrenheit - Location: REACH IN COOLER - COOK LINE
Violation Issued: No

Process/Item: FISH
Temperature: 41 Degrees Fahrenheit - Location: WALK IN COOLER
Violation Issued: No

Process/Item: MILK
Temperature: 41 Degrees Fahrenheit - Location: WALK IN COOLER
Violation Issued: No

Process/Item: CHEESE
Temperature: 41 Degrees Fahrenheit - Location: WALK IN COOLER
Violation Issued: No

Process/Item: MILK
Temperature: 41 Degrees Fahrenheit - Location: REACH IN COOLER - ASSISTED LIVING MEMORY PREP ROOM
Violation Issued: No

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

Inspection was completed with Joey Keen as the lead Health Regulation Division Nurse Evaluator completing the site survey.

Clgv Assisted Living Memory and Fireside (nursing facility) are connected by and shares the kitchen. Food for Clgv Assisted Living Memory is plated and transported from Fireside serving line.

Discussed highly susceptible populations, date marking, illness policy, sanitizer use, ware washing, temperature control, cleaning, pest control, vomit/fecal procedures, test kits, food storage, and food handling procedures.

Contact Health Regulation Division for plan review approval when facility/kitchen undergoes remodeling.

If any customer complains of illness, establishment is required to notify the Minnesota Department of Health and provide the foodborne illness hotline phone number to the customer: 1-877-366-3455

Type: Full
Date: *02/18/25*
Time: 11:30:00
Report: 1043251049
Clgv Assisted Living Memory

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1043251049 of 02/18/25.

Certified Food Protection Manager: Patrick Tuomala

Certification Number: 41337 Expires: 02/09/28

Inspection report reviewed with person in charge and emailed.

Signed:_____
Patrick Tuomala
Dining Director

Signed:_____
Blia Lor
Public Health Sanitarian I
651-355-0641
blia.lor@state.mn.us