Electronically Delivered

August 13, 2024

Licensee
The Guardian Home Care LLC
7814 Unity Avenue North
Brooklyn Park, MN 55443

RE: Project Number(s) SL36296015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 17, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Renee L. Anderson

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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36296	A. BUILDING: _____ B. WING _____	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GUARDIAN HOME CARE LLC	7814 UNITY AVENUE NORTH BROOKLYN PARK, MN 55443

(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: SL36296015-0 On July 15, 2024, through July 17, 2024, the Minnesota Department of Health conducted an initial survey at the above provider, and the following correction orders are issued. At the time of the survey, there were four (4) residents, all of whom received services under the provider's Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required	0 110		

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was identified with the Minnesota Board of Executives for Long-Term Services and Support (BELTSS) as the Director of Record for the licensee. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: LALD-A started employment on November 12, 2019, under the licensee's comprehensive home care license. On July 15, 2024, at 11:00 a.m., during a tour of the facility, LALD-A's assisted living director license, issued June 13, 2022, was observed to be displayed in the facility. On July 16, 2024, at 8:15 a.m., BELTSS website was accessed with LALD-A, and indicated LALD-A currently held an assisted living director	0 110		

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0 110	Continued From page 2 license, but LALD-A was not listed as the Director of Record for any licensee and was not listed as a shared director. On July 16, 2024, at 8:15 a.m., LALD-A stated she provided all the required information to BELTSS and indicated all the required information had been previously filled out. LALD-A stated she was not aware that she had not been listed as Director of Record for licensee with Health Facility Identification Number (HFID) 36296. On July 16, 2024, at 10:20 a.m., LALD-A handed surveyor verification she was listed as the Director of Record for the licensee, with an end date of July 16, 2024 (the same day). LALD-A stated she just filed the information with BELTSS on their website, and would need to go back to the BELTSS website and change the dates accordingly. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record	0 480		

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0 480	Continued From page 3 review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated July 16, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 660 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 include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled	0 660		

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0 660	Continued From page 4 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 interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included baseline testing, for one of two employees (licensed assisted living director (LALD)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The facility TB risk assessment, dated July 1, 2023, indicated the facility was at a low risk for TB transmission. LALD-A was hired November 12, 2019, and provided direct care and supervisory services for the licensee. LALD-A's employee record included a TB symptom screen dated December 20, 2022. LALD-A's employee record lacked documentation of IGRA (serum blood test) or TST (tuberculin skin tests).	0 660		

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0 660	Continued From page 5 On July 16, 2024, at 12:37 p.m., housing manager (HM)-C stated the licensee had a process in place where new hires would get TB tested at their own clinic and provide the facility with the results. HM-C further stated the licensee would accept TB tests completed within two months prior to hire date, as well as negative chest x-ray results. On July 16, 2024, at 1:10 p.m., LALD-A stated she has had a positive TST in the past, therefore, obtains a chest x-ray, and would locate the results, and place them in her employee file. On July 17, 2024, at 9:23 a.m., surveyor received an email from LALD-A indicating licensee reached out to her clinic to obtain a copy of her positive TST, as it had been completed a long time ago. LALD-A further indicated she currently worked at a hospital, and due to a history of a positive TST, a TB symptom screening would be completed every year. The licensee's Tuberculosis Infection General Infection Control Plan and Policies dated June 8, 2023, indicated licensee would implement a comprehensive TB screening program for all residents, staff, and volunteers upon admission or employment. Furthermore, licensee would conduct TB testing using appropriate methods such as TST or IGRA's, and based on the screening results, identify individuals who require further testing for TB. Follow the guidelines provided by the local health department or national TB control program for selecting the appropriate testing method and document the results of the TB testing accurately and maintain appropriate records.	0 660		

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0 660	Continued From page 6 The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include an annual facility TB risk assessment. The guidelines also indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding	0 680		

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0 680	Continued From page 7 missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 16, 2024, at 9:20 a.m., the EP binder, reviewed May 29, 2023, lacked the following requirements: - Policy and procedure to address role of facility under a waiver declared by the Secretary in accordance with section 1135 of the Act; - Must participate in an annual full-scale exercise that is community based OR conduct an annual,	0 680		

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0 680	Continued From page 8 individual, facility-based functional exercise OR if the facility experiences an actual emergency requiring activation of plan, facility is exempt from engaging in its next required full-scale exercise; - Conduct an additional annual exercise that may include: a second full-scale exercise that is community-based or an individual, facility based functional exercise OR mock disaster drill OR table-top exercise; - Analyze the facility's response to and maintain documentation of all drills, tabletop exercises and emergency events & revise plan as needed; - Policy and procedure to address arrangements with other facilities which: must address: development of arrangements with other facilities/providers to receive residents in the event of limitations/cessation of operations to maintain the continuity of services to residents; - Subsistence needs for staff and patients; - Procedure for tracking of staff and patients; - Policies and Procedures Including Evacuation; - Policies and Procedures for Sheltering in place: and - Development of Communication Plan that must include all the following names/contact information: staff, entities providing services under agreement, resident's physicians, other facilities, and volunteers. On July 16, 2024, at 10:30 a.m., licensed assisted living director (LALD)-A stated the EP binder lacked all the required conted listed above. LALD-A further stated licensee had conducted staff/resident fire drills; however, was unaware of all the required additional content. LALD-A further stated housing manager (HM)-C was responsible for ensuring the EP binder included all the required content. The licensee's Emergency Preparedness policy	0 680		

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0 680	Continued From page 9 dated August 23, 2020, indicated, "[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." The policy further indicated, the plan would consider the organization's commitment to provide services while ensuring the safety of its employees and residents, and the plan would be implemented as soon as the licensee was aware of the existence of an emergency." 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 that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to	0 780		

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0 780	Continued From page 10 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 facility failed to maintain and provide interconnected smoke alarms in the home as required for proper notification. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 16, 2024, from approximately, 1:30 p.m. to 2:45 p.m., survey staff toured the home with licensed assisted living director (LALD)-A. During the tour, survey staff observed LALD-A tested the smoke alarms inside sleeping rooms 1 and 3, and the required smoke alarms failed to sound locally inside rooms 1 and 3 and other required alarms in the home to operate and sound throughout. Survey staff noted that the voice-activated smoke alarm system indicated that seven devices were connected when LALD-A tested the smoke alarms, but no sound was produced or heard in the home for proper notification. Survey staff	0 780		

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0 780	Continued From page 11 explained to LALD-A that the smoke alarms in each sleeping room must sound and all smoke alarms in the home must be interconnected for proper notification. The interconnection of smoke alarms applies to all smoke alarms in the resident sleeping rooms and hallways. LALD-A stated they understood that all smoke alarms must be interconnected and sound throughout. LALD-A underderstood and verified the findings at the time of discovery and commented that the smoke alarms did sound last month when they tested them and will have them repaired. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 800 SS=C	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 of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of residents, visitors, and staff. This practice resulted in a level one violation (a	0 800		

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0 800	Continued From page 12 violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 16, 2024, from approximately 1:30 p.m. to 2:45 p.m., survey staff toured the home with licensed assisted living director (LALD)-A. During the tour, survey staff observed the following: -The doorbell did not ring or sound inside the house. Survey staff and LALD-A tested the doorbell and LALD-A concurred that it did not sound at the time of discovery. -The garage rain gutter downspout drain was disconnected and had missing pieces in the vertical position including the extension piece preventing rainwater from discharging away from the home. LALD-A stated that they had ordered the missing gutter drain pieces at the time of discovery. -The house number in front of the house was painted with brown with a brown color background which could prevent emergency vehicles/personnel from visibility from the street. Staff explained that the house number needs to be in a contrasting color to the background for emergency personnel visibility. LALD-A stated that it makes sense. On July 16, 2024, at approximately 3:15 p.m., at the exit interview, LALD-A understood and acknowledged the above findings. No further information was provided.	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36296	A. BUILDING: _____ B. WING _____	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GUARDIAN HOME CARE LLC	7814 UNITY AVENUE NORTH BROOKLYN PARK, MN 55443

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0 800	Continued From page 13 TIME PERIOD FOR CORRECTION: Twenty-one (21) 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36296	A. BUILDING: _____ B. WING _____	07/17/2024

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0 810	Continued From page 14 This MN Requirement is not met as evidenced by: Based on observation, documentation review, and interview, the licensee failed to provide all required contents on the fire safety and evacuation plan, the minimum number of fire evacuation drills, and the required minimum training of staff and residents on the fire safety and evacuation plan. This has the potential to directly affect the safety of visitors, staff, and all 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) 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 16, 2024, from approximately, 1:30 p.m. to 2:45 p.m., survey staff toured the home with licensed assisted living director (LALD)-A. During the tour, survey staff observed that the basement evacuation floor plan incorrectly labeled a storage room as a bedroom. LALD-A verified the finding at the time of discovery as LALD-A stated that the room is a storage room and not a bedroom and they will revise the plan to show the room as storage. On July 16, 2024, at approximately 3:15 p.m., a document and record review and interview with LALD-A indicated the following: -Document review indicated that the licensee did not include and identify specific fire protection	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36296	A. BUILDING: _____ B. WING _____	07/17/2024

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0 810	Continued From page 15 procedures for residents who are capable of self-evacuation on the proper actions to be taken in case of a fire or similar emergency. -Record review indicated the licensee failed to provide evacuation training to residents at least once per year. No record or log was provided or availabe for review to show any training offered to residents capable of assisting their evacuation during a fire or similar emergency. -Record review indicated the licensee lacked employee training on the facility fire safety and evacuation plan at least twice per year after new hire orientation. The review of the available records indicated only one training on fire safety in 2023. The finding was verified as the home's Fire Safety Plan, dated August 23, 2020, incorrectly stated that emergency training was provided at the time of new employee orientation and annually. -Record review of the available documentation indicated that evacuation drills had been conducted twice per year per shift and least once every other month as required. Record review indicated in the 2024 fire evacuation drill records, the licensee did not perform the required evacuation drills for the afternoon (second) shift of a three-shift work day. The finding was evident as the form used to document fire drills only included the morning and night shifts. LALD-A stated they used the wrong form for 2024. LALD-A understood and acknowledged the above findings during the interview. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		

Minnesota Department of Health
Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
6512014500

Type: Full
Date: *07/16/24*
Time: 11:46:30
Report: 1047241168

Food and Beverage Establishment Inspection Report

Location:
The Guardian Home Care Llc
7814 Unity Avenue North
Brooklyn Park, MN55443
Hennepin County, 27

Establishment Info:
ID #: 0038017
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7632966256
ID #:

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

The following orders were issued during this inspection.

4-600 Cleaning Equipment and Utensils

4-601.11C

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

DOOR OF OVEN HAD FOOD DEBRIS BUILD UP.

Comply By: 07/16/24

Surface and Equipment Sanitizers

Hot Water: = at 165 Degrees Fahrenheit
Location: Dishmachine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: Refrigerator- ham
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: Refrigerator- milk
Violation Issued: No

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

The inspection was conducted with the operator & R. Makela.

The establishment has a residential kitchen & serves food that is prepared that day. The kitchen has wood cabinets, tiled floor & walls, painted ceiling & walls, and a solid countertop.

Food and Beverage Establishment Inspection Report

A two basin sink is located in the kitchen. One sink basin is designated for hand washing. A residential dish machine is located in the kitchen.

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

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1047241168 of 07/16/24.

Certified Food Protection Manager: Adeshola Afolabi Wilson

Certification Number: FM119522 Expires: 10/13/26

Inspection report reviewed with person in charge and emailed.

Signed: _____

Gertrude Wilson
Operator

Signed: _____

Holly Sievers
Public Health Sanitarian 2
Metro Office
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Holly.Sievers@state.mn.us