DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 5, 2022

Administrator
Graceful Lodge Home Care
6430 June Avenue North
Brooklyn Center, MN 55429

RE: Project Number(s) SL35698015

Dear Administrator:

On April 20, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on February 18, 2022. The follow-up evaluation determined your agency had not corrected all of the state licensing orders issued pursuant to the February 18, 2022 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on February 18, 2022, found not corrected at the time of the April 20, 2022, follow-up evaluation and/or subject to penalty assessment are as follows:

0780-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (1) = $500.00

The details of the violations noted at the time of this follow-up evaluation completed on April 20, 2022 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order by the correction order date. The commissioner may request a copy of this documentation and the assisted living facility's action to respond to the correction orders in future evaluations, upon a complaint investigation, and as otherwise needed.

IMPOSITION OF FINES:

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.

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you have one opportunity to challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. This written request must be received by the Department of Health within 15 calendar days of the correction order receipt date. Please send your written request via email to the following:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970
Health.HRD.Appeals@state.mn.us

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. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

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.

We urge you to review these orders carefully. If you have questions, please contact Jess Gallmeier at 651-247-0268.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Sincerely,

Jess Gallmeier, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-247-0268 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35698	A. BUILDING: _____ B. WING _____	R 04/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACEFUL LODGE HOME CARE	6430 JUNE AVENUE NORTH BROOKLYN CENTER, MN 55429

(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 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: Project # SL35698015-1 On April 7, 2022 to April 20, 2022, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on February 18, 2022. At the time of the survey, there were 3 active residents receiving services under the Assisted Living license. As a result of the revisit, the following correction order is reissued.	{0 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	{0 480}		

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{0 480}	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (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: No further action required.	{0 480}		
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics;	{0 780}		

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{0 780}	Continued From page 2 (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the interconnection of all smoke alarms in the home as required by Minnesota Statutes, 144G.45, Subd. 2. This has the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On April 7, 2022, approximately from 10:05 a.m. to 10:40 a.m., survey staff toured the home with the licensed assisted living director (LALD)-D, about the interconnection of required smoke alarms. The home consisted of three bedrooms (#1, #2, and #3) on the main floor and two bedrooms (#4 and #5) on the lower level. At approximately 10:30 a.m., survey staff observed the lower level smoke alarm outside of bedrooms #4 and #5, and the smoke alarm inside	{0 780}		

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{0 780}	Continued From page 3 resident bedroom #5 on the lower-level floor failed to sound when the smoke alarms on the main level were tested. Survey staff explained to the LALD-D that all smoke alarms in the home including the alarms in the basement must be interconnected such that all other smoke alarms in the home must sound throughout for notification. The LALD-D confirmed the findings as he stated that he was focused on the smoke alarms on the main floor and that he will also need to order one more wireless battery smoke alarm. No additional information was provided. On April 7, 2022, at approximately 11:10 a.m., LALD-D acknowledged the above findings at the exit interview.	{0 780}		
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: No further action required.	{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	{0 810}		

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{0 810}	Continued From page 4 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. This MN Requirement is not met as evidenced by: No further action required.	{0 810}		
{0 820} SS=I	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including	{0 820}		

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{0 820}	Continued From page 5 assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: No further action required.	{0 820}		

Electronically Delivered

March 16, 2022

Administrator
Graceful Lodge Home Care
6430 June Avenue North
Brooklyn Center, MN 55429

RE: Project Number(s) SL35698015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on February 18, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health 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.

The enclosed State Form documents the state licensing orders. The Department of Health 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 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.

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

St - 0 - 0820 - 144g.45 Subd. 2 (g) - Fire Protection And Physical Environment - $3,000.00

St - 0 - 1390 - 144g.62 Subdivision 1 - Availability Of Contact Person To Staff - $3,000.00

The total amount you are assessed is $6,000.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction 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 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 the Department of Health within 15 calendar days of the correction order receipt date.

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

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.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Jessica Gallmeier, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jess.gallmeier@state.mn.us
Phone: 651-247-0268 Fax: 651-215-9697

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0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#3568015 On February 15, 2022, through February 16, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were three (3) residents receiving services under the provider's Assisted Living license. February 18, 2022, an immediate correction order was identified for SL35698015, tag identification 1390 and was issued to the licensee on March 10, 2022. On March 14, 2022, the immediacy of correction order 1390 was removed, however non-compliance remained at a scope and level of I. February 16, 2022, an immediate correction order was identified for SL35698015, tag identification 0820 and was issued to the licensee on March	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	

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0 000	Continued From page 1 11, 2022.	0 000		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop or implement a staffing plan to determine its staffing level. This had the potential to affect all 3 residents.	0 470		

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0 470	Continued From page 2 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: The licensee held an assisted living license, effective August 1, 2021. The licensee was licensed for a resident capacity of 5 residents and had a current census of 3 residents. During the entrance conference on February 15, 2022, at approximately 9:30 a.m., licensed assisted living director (LALD)-D explained how the licensee staffed its building. LALD-D questioned what a staffing plan was. The surveyor explained what a staffing plan was and LALD-D reiterated the licensee had not developed a staffing plan. The licensee's Staffing policy, dated August 1, 2021, indicated the clinical nurse supervisor would prepare and implement a twenty-four (24) hour daily staffing plan that would ensure adequate staffing to meet resident needs at all times. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		

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0 480	Continued From page 3	0 480		
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: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This had the potential to affect all three (3) residents in the Assisted Living facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include:	0 480		

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	35698	A. BUILDING: _____ B. WING _____	02/18/2022

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0 480	Continued From page 4 Please refer to the included document titled, Food and Beverage Establishment Inspection Report, dated February 15, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the required information related to the grievance procedure and contact information for the Office of Ombudsman for Long-Term Care and Mental Health and Developmental Disabilities, as well as information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). This had the potential to affect all the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 550		

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0 550	Continued From page 5 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 February 15, 2022, at approximately 11:30 a.m., during a facility-wide tour, observation revealed the licensee failed to post the required grievance procedure content in a conspicuous place. On February 15, 2022, at approximately 12:05 p.m., licensed assisted living director (LALD)-D confirmed the required grievance procedure content had not been posted . The licensee policy, Resident Grievances policy, dated August 1, 2021, did not include the new Assisted Living Licensure requirements related to posting information in a conspicuous place. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 570 SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it. This MN Requirement is not met as evidenced	0 570		

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0 570	Continued From page 6 by: Based on observation and interview, the licensee failed to display the current assisted living license at the main entrance of the assisted living building. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During an observation on February 15, 2022, at approximately 10:45 a.m., the original current license was not posted at facility entrances, hallways, dining area, or in living areas. On February 15, 2022, at approximately 10:55 a.m., licensed assisted living director (LALD)-D stated there was a current assisted living license dated August 1, 2021, displayed in the licensee's office. LALD-D stated he was not aware the license needed to be posted at the front entrance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 570		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for	0 640		

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0 640	Continued From page 7 reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to support protection and safety by not posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC), and failed to post the 911 emergency number in common areas and near telephones provided by the assisted living facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: During a building tour on February 15, 2022, at approximately 10:45 a.m., the surveyor noted the facility's common areas had no posting of the 911 emergency number, or information related to reporting suspected maltreatment to MAARC.	0 640		

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0 640	Continued From page 8 During an interview on February 15, 2022, at 11:05 a.m., licensed assisted living director (LALD)-D verified the required information was not posted in the common areas. The licensee's Emergency/911 policy, dated August 1, 2021, identified the procedure to contact 911 emergency services in the event of an emergency. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (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	0 650		

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0 650	Continued From page 9 required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee record contained training and competency evaluations for one of one unlicensed personnel (ULP)-B who performed delegated tasks. 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 had a hire date of October 6, 2021. ULP-B's record lacked any documentation that training and competency testing in delegated tasks had been completed. During interview on February 15, 2022, at 12:00 p.m., licensed assisted living director (LALD)-D stated the registered nurse (RN) had provided all training and orientation to ULP-B at the time of hire. During interview on February 15, 2022, at 2:45	0 650		

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0 650	Continued From page 10 p.m., RN-A stated all staff are trained by a RN and must return demonstrate competency for delegated tasks. RN-A stated because of a time constraint she was not able to completely document all of ULP-B's competency training and orienation but stated that ULP-B had completed all training on October 6, 2021. The licensee's Staff Orientation and Education policy was requested but not received. ULP-B's demonstrated delegated task competency records were requested but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) 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 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.	0 660		

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0 660	Continued From page 11 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 completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for two of two employees, registered nurse (RN)-A and unlicensed personnel (ULP)-B, with records reviewed. 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 facility TB risk assessment, dated August 1, 2021, indicated the facility was a low risk setting for TB transmission. RN-A RN-A had a hire date of January 1, 2021. RN-A provided direct care to residents of the assisted living. RN-A's employee record included a completed TB screening form, dated January 13, 2021. RN-A's employee record lacked documentation of a two-step TST or other evidence of TB screening such as a blood test.	0 660		

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0 660	Continued From page 12 ULP-B ULP-B had a hire date of October 6, 2021. ULP-B provided directed care to residents of the assisted living. ULP-B's employee record included a completed TB screening form, dated October 6, 2021. ULP-B's employee record lacked documentation of a two-step TST or other evidence of TB screening such as a blood test. During an interview on February 16, 2021, at 11:39 a.m., licensed assisted living director (LALD)-D stated he was not aware that RN-A or ULP-B did not have a two-step TST or other evidence of TB screening, such as a blood test. The Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, noted baseline screening for all health care workers (HCW) included a history and symptom screen, and testing for the presence of TB infection. The regulations noted a blood test should include the date of the test. The licensee's Tuberculosis Screening policy, dated August 1, 2021, indicated new staff will have a blood test or two step TST conducted, with results documented on the Baseline TB Screening Tool for Health Care Workers. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment	0 780		

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0 780	Continued From page 13 (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the interconnection of smoke alarms as required by Minnesota Statutes, 144G.45, Subd. 2. This has the potential to directly affect all resident(s), staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all	0 780		

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0 780	Continued From page 14 of the residents). The findings include: On February 16, 2022, between the hours of 10:05 a.m. and 11:10 a.m., survey staff toured the home with the licensed assisted living director (LALD)-D. The home consisted of three bedrooms (#1, #2 and #3) on the main floor and two bedrooms (#4 and #5) in the lower level. INTERCONNECTION OF SMOKE ALARMS At approximately 10:15 a.m., survey staff observed the smoke alarm inside resident bedroom #1 on the main floor only sounded local. Survey staff explained to the LALD-D that the smoke alarm must be interconnected with the home's smoke alarm system such that all other smoke alarms in the home must sound throughout for notification. The finding was evident when smoke alarms inside bedrooms #2 and #3 were tested by the LALD-D, and all sounded local only and not throughout. The LALD-D stated that all smoke alarms in the home were battery operated only smoke alarms and were not interconnected. Improper installation of smoke alarms prevents the early notification of fire for the residents and staff which can delay the response time of the evacuation of the entire home. Additional information provided: An email received on February 16, 2022, at 12:38 p.m. sent by the LALD-D, with an attached product specification for the proposed wireless smoke alarm system for interconnection. On February 16, 2022, at approximately 11:40 a.m., LALD-D acknowledged the above findings at the exit interview.	0 780		

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0 780	Continued From page 15 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment 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 all residents and staff. 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). On February 16, 2022, between the hours of 10:05 a.m. and 11:10 a.m., survey staff toured the home with the licensed assisted living director (LALD)-D, and the following findings were observed:	0 800		

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0 800	Continued From page 16 -The return/supply grilles located on the kitchen floor were damaged and not the correct size to provide for a smooth transition between the floor and the grilles, creating a dip and tripping hazard for residents and/or staff. -The trim for one of the sides of the bathroom door on the main floor was missing and/or removed from the wall. -The wall behind the bathroom door on the main floor had a hole that need to be patched. -The four-season porch was cluttered, unmaintained, uncleaned, and not in a good state of cleaniness. On February 16, 2022, at approximately 11:40 a.m., LALD-D acknowledged the above findings at the exit interview. No other information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) 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	0 810		

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0 810	Continued From page 17 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. This MN Requirement is not met as evidenced by: Based on interview, observation, and record review, the licensee failed to provide the full required content of documentation on the fire safety and evacuation plans, as well as failed to provide the required minimum number of evacuation drills, and the minimum required training of staff on evacuation. This has the potential to directly affect the health and safety of all residents, and staff. 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	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35698	A. BUILDING: _____ B. WING _____	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACEFUL LODGE HOME CARE	6430 JUNE AVENUE NORTH BROOKLYN CENTER, MN 55429

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0 810	Continued From page 18 of the residents). The findings include: On February 16, 2022, between the hours of 10:05 a.m. and 11:10 a.m., survey staff toured the home with the licensed assisted living director (LALD)-D. On February 16, 2022, at approximately 11:10 a.m., survey staff reviewed the fire safety and evacuation plan documentation, training policies and procedures, and related records. FIRE SAFETY AND EVACUATION PLAN: -The documentation lacked site-specific procedures for employee fire protection details necessary for the residents including procedures for their movements, and relocation during a fire or similar, and written instructions for addressing any unique resident situation during evacuation including for residents who are wheelchair-bound, or needing assistance during an evacuation. During the tour, survey staff observed one resident who was wheelchair-bound and/or needing assistance during an evacuation. -The documentation lacked fire protection procedures for residents. TRAINING The policy documentation included the minimum required content of employee training on the fire safety and evacuation plan upon hiring and at least twice per year thereafter, but lacked documented records of employee training. FIRE DRILLS AND EVACUATION The policy documentation included the content of minimum numbers of required evacuation drills that must be performed by employees twice per year per shift, with at least one evacuation drill	0 810		

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0 810	Continued From page 19 every other month, but insufficient numbers of evacuation drills were performed. Documented records showed the last evacuation drill performed was on 11/24/2021 without a specific time or evacuation details noted. On February 16, 2022, at approximately 11:40 a.m., the LALD-D acknowledged the above findings at the exit interview. No other information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 810		
0 820 SS=I	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure all facility physical elements, including, the minimum size egress windows on the main floor resident rooms, do not create a distinct hazard to residents and staff. This	0 820		

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	35698	A. BUILDING: _____ B. WING _____	02/18/2022

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0 820	Continued From page 20 affected three resident rooms, #1, #2, and #3 on the main floor. 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: On February 16, 2022, between the hours of 10:05 a.m. and 11:10 a.m., survey staff toured the home with the licensed assisted living director (LALD)-D. The home consisted of three bedrooms (#1, #2 and #3) on the main floor and two bedrooms (#4 and #5) in the lower level. At approximately 10:30 a.m., survey staff measured the windows in bedroom #2 on the main floor and explained to the LALD-D that the windows in the bedroom did not meet the minimum size egress window openings required for safe egress. At least one window must meet the minimum window opening size of at least 20 inches in height with a total of at least 648 square inches (4.5 square feet) required for egress window openings for bedrooms for assisted living facilities. The window opening dimensions measured in bedroom #2 were 12 inches in height and 26 inches in width, a total of 312 square inches (2.16 square feet). Survey staff noted that the top window pane of each window was removable for cleaning, but did not count toward the required window openings for safe egress. The LALD-D stated all three bedrooms	0 820		

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	35698	A. BUILDING: _____ B. WING _____	02/18/2022

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0 820	Continued From page 21 on the main floor were constructed with the same size window openings. Survey staff further clarified that the minimum size escape requirements applied to all three bedrooms. The LALD-D stated that the windows were there when he bought the home. Additional information provided: -An email received on February 16, 2022, at 6:50 p.m. sent by the LALD-D, with an attached rental permit from the City of Brooklyn Center. TIME PERIOD FOR CORRECTION: Immediate Owner has acknowledged the immediate correction order and is taking steps to mitigate, however, as of 03/16/2022, immediacy remains.	0 820		
01390 SS=I	144G.62 Subdivision 1 Availability of contact person to staff (a) Assisted living facilities must have a registered nurse available for consultation by staff performing delegated nursing tasks and must have an appropriate licensed health professional available if performing other delegated services such as therapies. 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)-A was available 24 hours a day, seven days a week to provide consultation to staff performing delegated nursing tasks and services. This had the potential to affect all 3 residents. This practice resulted in a level three violation (a violation that harmed a resident's health or safety,	01390	On March 14, 2022, the immediacy of correction order 1390 was removed, however non-compliance remains at a scope and level of I.	

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01390	Continued From page 22	01390		

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:

Surveyor arrived at licensee address on February 15, 2022, at approximately 10:15 a.m. Upon arrival surveyor noted an ambulance in the licensee driveway. A resident (R1) was being escorted out of the licensee home by two emergency medical technicians (EMT) and placed on an ambulance gurney. R1 was then placed into the ambulance with the EMTs and door was closed.

Surveyor entered licensee home and was greeted by a staff member. Staff member escorted surveyor to area where interview with LALD-D would be taking place; EMTs returned with R1 and stated they had checked R1's blood pressure three times and results were normal. EMTs felt R1did not need to go to the hospital. R1 was in agreement.

On February 15, 2022, at approximately 11:00 a.m., licensed assisted living director (LALD)-D stated the licensee had one registered nurse (RN)-A, who spent "every weekend" and was on-call 24-hours a day, seven days a week. LALD-D stated RN-A held a full-time RN position elsewhere.

Licensee provided medication administration and other delegated nursing tasks scheduled throughout the day. RN-A was employed at another location which limited the ability to

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01390	Continued From page 23	01390		

promptly consult with staff. LALD-D stated there was no other RN coverage if RN-A was ill or unavailable to consult.

LALD-D stated RN-A worked full time day shifts at a hospital, but she did not know what days RN-A worked (Monday through Friday or a rotating schedule). LALD-D stated RN-A was "always available to us" via phone calls or text messages. Unlicensed personnel (ULP)-C was not able to reach RN-A to inform of R1's blood pressure results and to get direction from RN-A.

During an interview on February 15, 2022, at 2:15 p.m., RN-A stated she was returning a call to the licensee and stated RN-A was on a lunch break at the time of the call. RN-A also stated staff who provide direct patient care at the hospital where RN-A was employed, were not allowed to carry their personal cell phones on them during work times. Staff were allowed, however, to have their personal phones on them during their break times. RN-A stated this was the first time the licensee was not able to reach her. RN-A explained normally the staff have been immediately able to speak with RN-A when they called and that today was a "one off".

The licensee's August 1, 2021, dated, Delegation of Assisted Living Tasks policy, indicated that an RN will be readily available to staff performing delegated services via phone or by other appropriate means during times when the staff is performing services.

No further information was provided.

TIME PERIOD FOR CORRECTION: Immediate

UPDATE On March 14, 2022, the immediacy of

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01390	Continued From page 24 correction order 1390 was removed, however non-compliance remains at a scope and level of I. TIME PERIOD FOR CORRECTION: Two (2) days	01390		

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

Type: Full
Date: *02/15/22*
Time: 11:35:20
Report: 1024221036

Food and Beverage Establishment Inspection Report

Location:
Graceful Lodge Home Care
6430 June Avenue North
Brooklyn Center, MN55429
Hennepin County, 27

Establishment Info:
ID #: 0039305
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 7636570611
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.

2-200 Employee Health

2-201.11C ** Priority 1 **

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.

NO ILLNESS LOG PRESENTED AT TIME OF INSPECTION. COPY PROVIDED.

Comply By: 02/15/22

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) ** Priority 1 **

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

OBSERVED CARTONS OF EGGS STORED ABOVE READY TO EAT FOODS SUCH AS MACARONI AND CHEESE AND JUICE. ADVISED TO REARRANGE TO PREVENT CROSS-CONTAMINATION.

Comply By: 02/15/22

7-200 Toxic Supplies and Applications

7-204.11 ** Priority 1 **

MN Rule 4626.1620 Discontinue using chemical sanitizers, including chemical sanitizing solutions generated on site and other chemical antimicrobials on food-contact surfaces that do not meet the requirements specified in 40 CFR part 180, section 180.940, or part 180, subpart E, section 180.2020.

ESTABLISHMENT USING LEMON SCENTED CLOROX WIPES. NO MEASURABLE SANITIZER ON SITE. DISCUSSED USING NON SCENTED CHLORINE SOLUTION.

Comply By: 02/15/22

7-200 Toxic Supplies and Applications

7-207.11B ** Priority 1 **

MN Rule 4626.1660B Label and locate personal medications in areas that do not contaminate food, equipment, linens, and single-service and single-use articles.

OBSERVED LABELED INSULIN IN UNLOCKED AREA IN FOOD COOLER. ADVISED TO LOCATE MEDICATION TO AN AREA THAT DOES NOT CONTAMINATE FOOD.

Comply By: 02/15/22

2-500 Responding to contamination events

2-501.11 ** Priority 2 **

MN Rule 4626.0123 Provide employees with procedures to follow for cleanup of vomit or fecal matter in the establishment. The procedures must minimize the spread of contamination to food and surfaces within the facility, and minimize the exposure of employees and consumers to contamination.

NO VOMIT/FECAL MATTER CLEAN UP PROCEDURES ESTABLISHED. FACT SHEETS PROVIDED.

Comply By: 02/15/22

4-300 Equipment Numbers and Capacities

4-302.12B ** Priority 2 **

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

NO THERMOMETERS ON SITE TO TEST FOOD TEMPERATURES. PROVIDE AND MAINTAIN ON SITE.

Comply By: 02/15/22

4-300 Equipment Numbers and Capacities

4-302.13B ** Priority 2 **

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

NO IRREVERSIBLE THERMOMETER OR TEMPERATURE TEST STRIPS AVAILABLE ON SITE TO TEST UTENSIL SURFACE TEMPERATURE OF DISHWASHING MACHINE. PROVIDE AND MAINTAIN.

Comply By: 02/15/22

2-100 Supervision

2-102.12AMN

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

NO CFPM EMPLOYED. DOCUMENTATION WAS PROVIDED TO REGISTER FOR APPROVED FOOD SAFETY COURSE AND MDH CERTIFICATION.

Comply By: 02/15/22

Surface and Equipment Sanitizers

Utensil Surface Temp: = at 160 Degrees Fahrenheit
Location: DISHWASHING MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding/MAC'N'CHEESE
Temperature: 40 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Process/Item: Reheat Temp/CHICKEN
Temperature: 135 Degrees Fahrenheit - Location: MICROWAVE
Violation Issued: No

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

DISCUSSED ALL ORDERS ON SITE WITH HOUSE MANAGER, EUPHENIA BREWER AND NURSING EVALUATOR ELYSE JONES. DISCUSSED THE FOLLOWING WITH HOUSE MANAGER:

- EMPLOYEE ILLNESS LOG AND EXCLUSION POLICY.
- VOMIT AND FECAL MATTER CLEAN UP PROCEDURES.
- CFPM.
- THERMOMETER USE.
- THERMOMETER CALIBRATION AND FREQUENCY.
- DATE MARKING AND DISCARD DATE.
- PROPER STACKING ORDER TO AVOID CROSS CONTAMINATION.
- PROPER TEMPERATURES FOR HOT AND COLD HOLDING, REHEATING, AND COOLING.
- PROPER SANITIZING LEVELS FOR AND CHLORINE.
- SAME DAY SERVICE: ESTABLISHMENT WAS MAINTAINING LEFTOVERS AFTER MEALS WERE PREPPED. ADVISED TO DISCONTINUE METHOD AND ITEMS WERE DISCARDED ON SITE.
- OBSERVED KITCHEN TO HAVE INTACT WOOD CABINETS AND LAMINATE FLOORING. MONITOR FOR DETERIORATION.

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 1024221036 of 02/15/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Signed:_____

EUPHENIA BREWER
HOUSE MANAGER

Signed:_____

Sheng Yang
Public Health Sanitarian I
Freeman Building
651-201-3985
sheng.yang@state.mn.us