



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 2, 2024

Licensee

Tender Care Group Homes LLC
2640 Polk Street Northeast
Minneapolis, MN 55418

RE: Project Number(s) SL35977015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 5, 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,



Jodi Johnson, Supervisor

State Evaluation Team

Email: Jodi.Johnson@state.mn.us

Telephone: 507-344-2730 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35977	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/05/2024
NAME OF PROVIDER OR SUPPLIER TENDER CARE GROUP HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2640 POLK STREET NE MINNEAPOLIS, MN 55418			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL35977015-0 On June 3, 2024, through June 5, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were four 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 licensed 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.		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that:	0 470			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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0 470	Continued From page 1 (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 observation, interview, and record review, the licensee failed to ensure the required staffing plan was developed and posted This had the potential to affect the four residents residing in the facility, 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	0 470			

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0 470	Continued From page 2 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee failed to develop and implement a staffing plan for determining it's staffing level based on the following: -each resident's needs, as identified in the resident's service plan and assisted living contract. -each resident's acuity level, as determined by the most recent assessment or individualized review. -the ability of staff to timely meet the resident's scheduled and reasonably foreseeable unscheduled needs given the physical layout of the facility premises; and -whether the facility has a secured dementia care unit, and staff experience, training, and competency. On June 3, 2024, at 11:00 a.m. during the entrance conference, clinical nursing supervisor (CNS)-A stated the licensee developed and implemented a staffing plan and evaluated the plan twice per year. CNS-A stated the staffing plan was posted near the front entrance along with their other required postings. On June 4, 2024, at 11:45 a.m. during the facility tour, a weekly staff schedule was observed posted near the front entrance but lacked the date and the employees' titles. In addition, CNS-A's days and hour of works were not included on the posting. At the same time, CNS-A stated a staffing plan had not been developed to address the content as required and	0 470			

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0 470	Continued From page 3 listed above. CNS-A further explained staff discussed staffing during quality improvement (QI) meetings but did not assess resident needs to determine appropriate staffing levels. CNS-A further stated, "We were not clear on how we were to do it." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470			
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food	0 480			

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0 480	Continued From page 4 and Beverage Establishment Inspection Report dated, June 4, 2024, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480			
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee	0 780			

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0 780	Continued From page 5 failed to provide interconnected smoke alarms that complied with fire protection requirements. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On June 3, 2024, at 1:00 p.m., survey staff toured the home with clinical nurse supervisor (CNS)-A. During the tour, survey staff observed the smoke alarm installed in unoccupied bedroom 4 was not activated when the other smoke alarms in the home were tested. The smoke alarm installed in bedroom 4 was not interconnected with the other smoke alarms in the dwelling unit. During an interview on June 5, 2024, at 9:00 a.m., CNS-A verified the smoke alarm in bedroom 4 was not interconnected. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780			
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a	0 790			

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0 790	Continued From page 6 minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain and install portable fire extinguishers as required by statute. This deficient condition 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) 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 June 3, 2024, at 1:00 p.m., survey staff toured the home with clinical nurse supervisor (CNS)-A. During the tour, survey staff observed the following: 1. Monthly inspections had not been recorded on the back of the tags attached to the fire extinguishers installed in the facility. Fire extinguisher inspections must be conducted every month to ensure that each extinguisher is in its designated place, that it has not been tampered with, and that there is no obvious physical damage or condition that would interfere	0 790			

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0 790	Continued From page 7 with its use or operation. Records must be maintained to document when each fire extinguisher was inspected and who performed the inspection. 2. The fire extinguishers installed in the facility measured 59 inches from the floor to the bottom of the fire extinguisher. Fire extinguishers must be installed with a maximum height of 60 inches from the floor to the top of the fire extinguisher. During an interview on June 5, 2024, at 9:00 a.m., CNS-A verified monthly fire extinguisher inspections were not completed and the height of the installed fire extinguishers was too high. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790			
0 800 SS=E	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 provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect a limited number of residents, staff, and visitors.	0 800			

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0 800	Continued From page 8 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). The findings include: On June 3, 2024, at 1:00 p.m., survey staff toured the home with clinical nurse supervisor (CNS)-A. During the tour, survey staff observed the following: 1. The closet doors were off the track in unoccupied bedroom 4. 2. In resident bedroom 3, the window blind was missing several slats. 3. The exterior moulding on the back door was deteriorated. During an interview on June 5, 2024, at 9:00 a.m., CNS-A verified these items required repair. TIME PERIOD FOR CORRECTION: Seven (7) 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	0 810			

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0 810	Continued From page 9 (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: Based on record review and interview, the licensee failed to develop a fire safety and evacuation plan with the required content. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of	0 810			

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0 810	Continued From page 10 the residents). The findings include: On June 3, 2024, at 1:00 p.m., survey staff toured the home with clinical nurse supervisor (CNS)-A. During the tour, survey staff observed numbers were posted at the resident bedroom doors. On June 4, 2024, the licensee provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and employee evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN Record review of the available documentation indicated the licensee failed to identify the location and number of resident sleeping rooms on the FSEP floor plan for the main level of the home. An accurate floor plan is required to provide efficient communication for exiting in the event of a fire or similar emergency. The FSEP included a Fire Safety Policy dated August 1, 2021. The fire safety policy was a template and had not been developed for the facility location. The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The employee actions were limited to the RACE acronym (Remove, Alarm, Confine, and Evacuate). The FSEP inappropriately referenced pull fire alarms. The FSEP did not identify specific fire protection procedures necessary for residents evident by limited instructions directing residents to stoop or	0 810			

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0 810	Continued From page 11 crawl to avoid smoke. During an interview on June 5, 2024, at 9:00 a.m., CNS-A verified the FSEP did not include the required information. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders;	01500			

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(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
01500	Continued From page 12 (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of two employees (clinical nurse supervisor (CNS)-A) received at least eight hours of annual training for each 12 months of employment. 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	01500			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35977	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/05/2024
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01500	Continued From page 13 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: CNS-A's date of hire was May 21, 2020. In addition, CNS-A was also the licensed assisted living director (LALD) of the facility. CNS-A's employee record lacked evidence of completion of at least eight hours of annual training during the past 12 months of employment in the following areas. -reporting maltreatment of vulnerable adults or minors -review of provider's policies and procedures -principles of person-centered planning/service delivery On June 4, 2024, at 12:40 p.m. CNS-A stated although they did complete some of the required annual training, they did not complete eight hours to fulfill the annual training requirements. CNS-A stated her employee file indicated she completed less than three (2.75) of the eight hours required for annual employee training. The licensee lacked a current policy for annual training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500			

Type: Full
Date: 06/04/24
Time: 11:25:00
Report: 1039241156

Food and Beverage Establishment Inspection Report

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Location:

Tender Care Group Homes Llc
2640 Polk Street Ne
Minneapolis, MN55418
Hennepin County, 27

Establishment Info:

ID #: 0038176
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6124071723
ID #:

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

The following orders were issued during this inspection.

3-300B 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.

SHELL EGGS STORED OVER PRODUCE, READY TO EAT FOODS IN REFRIGERATOR. DISCUSSED HOW TO SEPARATE RAW ANIMAL PRODUCE FROM OTHER FOODS WITH PERSON-IN-CHARGE. COMPLY WITH ABOVE. GUIDANCE DOCUMENT SENT WITH REPORT.

Comply By: 06/04/24

3-500C Microbial Control: date marking

3-501.17B ** Priority 2 **

MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.

NO DATE MARK PRESENT ON MILK CONTAINER OPENED MORE THAN 24 HOURS. COMPLY WITH ABOVE. GUIDANCE DOCUMENT ON DATE MARKING SENT WITH REPORT.

Comply By: 06/04/24

4-300 Equipment Numbers and Capacities

4-302.13B ** Priority 2 **

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

NO UTENSIL SURFACE TEMPERATURE MEASURING DEVICE IS PRESENT IN KITCHEN. ACQUIRE. GUIDANCE SENT WITH REPORT.

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Food and Beverage Establishment Inspection Report

Comply By: 06/18/24

Surface and Equipment Sanitizers

Utensil Surface Temp: = at >170 Degrees Fahrenheit
Location: DISHWASHING MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: MILK
Temperature: 38 Degrees Fahrenheit - Location: COLD HOLD IN REFRIGERATOR
Violation Issued: No

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

The inspection was completed with the person in charge and reviewed with MDH nurse evaluator Mary Bruess.

The kitchen is of residential build and should serve food for same-day service only.

The kitchen has wood cabinets with hollow base, tile floor, painted walls and ceiling and laminate countertops. The laminate countertops show signs of wear and should be repaired or replaced so they are durable, smooth and easily cleanable.

The kitchen refrigerator/freezer are of residential grade.

A 2-compartment sink is present in kitchen. 1 compartment is designated for handwashing only.

A residential dishwashing machine is present in the kitchen. Per color-change thermo test strip, the dish washing machine achieves a utensil surface temperature of >170 degrees F.

A supply of single-use gloves is present in kitchen. A thin-probe food thermometer is present in kitchen.

Discussed the following with the person-in-charge: minimum cook temps for animal proteins, food source, foodborne illness symptoms and exclusion of ill employees, avoiding bare hand contact with ready to eat foods, handwashing, sanitizing, thawing of frozen meat.

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Food and Beverage Establishment Inspection Report

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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 1039241156 of 06/04/24.

Certified Food Protection Manager Sumaya Ahmed

Certification Number: FM119948 Expires: 11/14/26

Inspection report reviewed with person in charge and emailed.

Signed: _____

Sumaya Ahmed
director

Signed: _____

Aron Goodner
Public Health Sanitarian I
Freeman Building
aron.goodner@state.mn.us