Electronically Delivered
February 2, 2022

Administrator
Roitenberg Family Assisted Liv
3610 Phillips Parkway South
Saint Louis Park, MN 55426

RE: Project Number(s) SL21691015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on January 6, 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, no immediate fines are assessed.

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 surveys. 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.

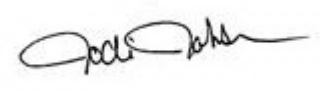
A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. 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

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,



Jodi Johnson, Supervisor
Health Regulation Division
State Evaluation Team
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Email: jodi.johnson@state.mn.us
Telephone: 507-696-2437 Fax: 651-215-9697

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21691	A. BUILDING: _____ B. WING _____	01/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROITENBERG FAMILY ASSISTED LIV	3610 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426

(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(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#21691015 On, January 3, 2022, through January 6, 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 51 residents receiving services under the provider's Assisted Living with Dementia Care license.	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: 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 51 residents residing at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report	0 480		

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0 480	Continued From page 2 dated January 4, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 480		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the	0 680		

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0 680	Continued From page 3 licensee failed to comply with the frequency of inspection, maintenance, and load test requirements for the facility's emergency power system (permanent generator) as part of the facility's emergency disaster and preparedness plan as required under Minnesota Rules, Part 4659.0100. This had the potential to affect the current resident receiving services under the assisted living license, as well any staff and visitors to the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a 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 January 4, 2022, at approximately 2:00 p.m. survey staff received the documentation related to inspection, maintenance, and load test records of the emergency power generator as part of the facility's shelter in place emergency disaster and preparedness plan for review. On January 4, 2022, at approximately 3:00 p.m. documentation review revealed the licensee failed to provide the minimum frequency of inspection and load test requirements for the emergency power generator as outlined under NFPA 110, (as referenced under the Code of Federal Regulations, title 42, section 483.73) to ensure proper performance of the generator as follow: -No records of weekly inspections of the	0 680		

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0 680	Continued From page 4 generator systems. -Insufficient numbers of monthly generator load tests. The last generator load test report showed tests were performed on December 20, 2021, November 30, 2021, and October 28, 2021. -Insufficient numbers of monthly transfer switch operation tests. Based on the records of the last generator load test reports, the transfer switch operation tests would also be on December 20, 2021, November 30, 2021, and October 28, 2021. On January 4, 2022, at approximately 5:00 p.m. the licensed assisted living director and operations project coordinator(OPC)-L confirmed the findings during the interview. Survey staff agreed to receive additional records within the next 24 hours for the OPC-L to retrieve any missing generator testing and inspection records from other employees for further review. On January 6, 2022, an extension was granted to the licensee to provide additional information by end of Monday, January 10, 2022, but, no additional information was received. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
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.	0 800		

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0 800	Continued From page 5 This MN Requirement is not met as evidenced by: Based observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This has the potential to directly affect residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: On January 4, 2022, between 10:40 a.m. and 2:00 p.m. survey staff toured with the the operations project coordinator (OPC)-L and licensed assisted living facility (LALD)-G. On January 4, 2022, at approximately 11:30 a.m., survey staff observed the ceilings in the hallways of the dementia care unit were opened with fully exposed wiring, ductwork, piping, etc, and appeared to be under construction and/or remodeling with residents utilizing the hallways and shared living areas. Survey staff asked LALD-G for clarifications on the scope of work and if required construction permits were obtained for the work. LALD-G explained that they were only replacing ceiling tiles, repainting the walls, and replacing the carpet in the common areas for an upgrade, and will check with the construction manager for the permits.	0 800		

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0 800	Continued From page 6 On January 4, 2022, at approximately 5:00 p.m. during the interview with LALD-G and OPC-L survey staff explained the concerns of the remodeled work in hallways of the dementia care unit as it related to the health and well-being of residents. Although the smoke alarms and sprinkler system in the hallways all appeared to be intact and operational, staff explained that the removal of the hallway ceiling tiles raised concerns of exposure and inhalation of airborne dust for the residents in the dementia care unit. Based on this observation, survey staff explained to LALD-G and the OPC-L that the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operations to protect the residents while performing remodel work as required by statutes. The licensee lacked a policy and/or protocols to protect the residents during building remodeling work. LALD-G explained that they used Hepta filters during the ceiling removal work. Survey staff agreed that the Hepta filters would be a good measure to remove the dust from the building through the building ventilation system. However, the Hepta filters would not prevent dust and debris to be airborne during the removal of the ceiling tiles. Staff advised the LALD and the OPC-L to adopt protocols and/or policies to address remodel through shielding or separation of work space in the facility to maintain the environment that would be protective for the residents including the scheduled carpet removal and replacement work. LALD-G confirmed the finding. On January 4, 2022, at approximately 11:45 a.m., survey staff observed the keypad for the secured door to the outdoor garden area near room B113 was on bypassed due to the number "0" on the	0 800		

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0 800	Continued From page 7 keypad not operating to allow staff to use the secured door as intended. This "0" was part of an access code and must be repaired to protect residents from unintentionally entering the outdoors without supervision and not monitored leading to potential harm. In addition, the nonoperational keypad did not allow staff to use the door using the access code to re-enter the building after exiting. LALD-G and the OPD-L confirmed the finding. No additional information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=E	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility.	0 810		

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0 810	Continued From page 8 (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 provide documentation on the required frequency of training on fire safety and evacuations for employees and residents. This has the potential to directly affect the safety of all residents receiving assisted living care and employees. 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). Findings include: On January 4, 2022, at approximately 4:00 p.m. survey staff received the facility fire safety and evacuation plan related documentation from the Chief of Operations (CO)-K for review.	0 810		

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0 810	Continued From page 9 -The documentation lacked the required minimum frequency of training twice a year for training of employees after hiring on fire safety and evacuation. -The documentation lacked the content of required annual training of residents that can self-assist in their evacuation on the proper actions to be taken in the event of a fire including movement, evacuation, or relocation. On January 4, 2022, at approximately 5:00 p.m. LALD-G confirmed the findings during the interview. The LALD-G explained that their policy was to provide employee training upon hire and annually for two consecutive years. On January 5, 2022, at 5:40 p.m. additional policies and procedures were provided via email by LALD-G. The information sent has the same content as the information CO-K provided to survey staff on-site for document review. The additional information did not include all the required training content as outlined above. TIME PERIOD FOR CORRECTION: Seven (7) days	0 810		
0 910 SS=B	144G.50 Subd. 2 Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the license number of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable;	0 910		

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0 910	Continued From page 10 (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview, and document review the licensee failed to have a license number listed on the contract as required for three of four residents' (R3, R4, R5) contracts reviewed. 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 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: R3 On January 4, 2022, at 12:00 p.m. unlicensed personnel (ULP-C) administered insulin to R3. R3's Resident Negotiated Service Plan with Schedule dated October 22, 2021, indicated services included assistance with transfers, bathing, dressing, grooming, blood sugar checks, and medication administration. R3's Assisted Living Contract dated August 1, 2021, lacked the license number of the facility. R4 On January 4, 2022, at 11:38 a.m. ULP-C	0 910		

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0 910	Continued From page 11 obtained R4's blood sugar reading. R4's Resident Negotiated Service Plan with Schedule dated October 1, 2021, indicated services included assistance with transfers, bathing, dressing, grooming, blood sugar checks, and medication administration. R4's Assisted Living Contract dated October 1, 2021, lacked the license number of the facility. R5 On January 4, 2022, at 1:03 p.m. ULP-F administered an eye drop to R5. R5's Resident Negotiated Service Plan with Schedule dated August 3, 2021, indicated services included assistance with bathing, dressing and grooming reminders and medication administration. R5's Assisted Living Contract dated August 3, 2021 lacked the license number of the facility. On January 5, 2022, at 12:05 p.m. licensed assisted living director (LALD)-G verified the license number was not included on the above resident contracts. A policy related to the content of the contract was requested but not available. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 920	Continued From page 12	0 920		
0 920 SS=C	144G.50 Subd. 2 Contract information (c) The contract must include: (1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; (2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; (3) a delineation of the cost and nature of any other services to be provided for an additional fee; (4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; (5) a delineation of the grounds under which the resident may be discharged, evicted, or transferred or have services terminated; (6) billing and payment procedures and requirements; and (7) disclosure of the facility's ability to provide specialized diets. This MN Requirement is not met as evidenced by: Based on interview, and document review the licensee failed to identify the license held an Assisted Living Facility with Dementia Care (ALFDC) license as required for four of four residents' (R2, R3, R4, R5) contracts reviewed. This had the potential to affect all 51 residents. 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	0 920		

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0 920	Continued From page 13 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: R2 On January 4, 2021, unlicensed personnel (ULP)-J stated she had completed urinary catheter (a soft hollow tube, which is passed into the bladder to drain urine) care for R2 earlier in the morning. R2's Resident Negotiated Service Plan with Schedule dated August 23, 2021, indicated services included assistance with bathing, catheter cares, brace placement, and medication administration. R2's Assisted Living Contract dated August 9, 2021, failed to disclose the category of the assisted living license as an ALFDC. R3 On January 4, 2022, at 12:00 p.m. ULP-C administered insulin to R3. R3's Resident Negotiated Service Plan with Schedule dated October 22, 2021, indicated services included assistance with transfers, bathing, dressing, grooming, blood sugar checks, and medication administration. R4's Assisted Living Contract dated October 1, 2021, failed to disclose the category of the assisted living license as an ALFDC.	0 920		

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0 920	Continued From page 14 R4 On January 4, 2022, at 11:38 a.m. ULP-C obtained R4's blood sugar reading. R4's Resident Negotiated Service Plan with Schedule dated October 1, 2021, indicated services included assistance with transfers, bathing, dressing, grooming, blood sugar checks, and medication administration. R4's Assisted Living Contract dated October 1, 2021, failed to disclose the category of the assisted living license as an ALFDC. R5 On January 4, 2022, at 1:03 p.m. ULP-F administered an eye drop to R5. R5's Resident Negotiated Service Plan with Schedule dated August 3, 2021, indicated services included assistance with bathing, dressing and grooming reminders and medication administration. R5's Assisted Living Contract dated August 3, 2021, failed to disclose the category of the assisted living license as an ALFDC. On January 5, 2022, at 12:05 p.m. licensed assisted living director (LALD)-G verified the above resident contracts failed to disclose the category of the assisted living license as an ALFDC. All resident contracts were the same and identified the licensee as having an assisted living license instead of an ALFDC. A policy for assisted living contract was requested, but not provided.	0 920		

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0 920	Continued From page 15 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 920		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual begins working for	01440		

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01440	Continued From page 16 the facility for one of three unlicensed personnel (ULP)-E 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, 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: On January 4, 2022, at 11:22 a.m. ULP-E administered medication to R9. ULP-E was hired on September 23, 2021, to provide direct care services to residents at the assisted living. ULP-E's employee record lacked documentation of a registered nurse (RN) supervising ULP-E performing delegated tasks within 30 days of beginning work with the licensee. On January 6, 2022, at 2:30 p.m. interim home care director (IHCD)-A confirmed ULP-E's 30-day supervision of delegated tasks had been missed. The licensee's 6.17 Supervision of Staff - Delegated Services policy dated August 1, 2021, indicated direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual began work and first performed the delegated tasks for residents and documentation of supervision activities would be retained in the employee's record.	01440		

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01440	Continued From page 17 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01440		
01620 SS=E	144G.70 Subd. 2 Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the licensee failed to complete 90-day assessments timely for two of four residents (R3, R4) and a change of condition assessment for	01620		

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01620	Continued From page 18 one of one resident (R2) after a hospitalization 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 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: R3 R3's record lacked 90-day assessments as required. R3's diagnoses included, but were not limited to, diabetes mellitus (condition results from insufficient production of insulin, causing high blood sugar), congestive heart failure (progressive heart disease that affects pumping action of the heart muscles. This causes fatigue, shortness of breath), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), generalized anxiety disorder (condition with exaggerated tension, worrying, and nervousness about daily life events), chronic pain, peripheral vascular disease (narrowing of arteries which results in reduced blood flow to head, arms, stomach and usually affects the arteries in the legs), and muscle weakness. R3's Resident Negotiated Service Plan with Schedule dated October 22, 2021, indicated services included assistance with transfers, bathing, dressing, grooming, blood sugar checks,	01620		

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01620	Continued From page 19 and medication administration. On January 4, 2022, at 12:00 p.m. unlicensed personnel (ULP-C) administered insulin to R3. R3's last two comprehensive assessments were requested. A 90-day assessment dated July 20, 2021, and October 22, 2021, were provided. There was a total of 94 days between the two assessments. On January 5, 2022, at 5:35 p.m. interim home care director (IHCD)-A confirmed R3's assessments were greater than 90 days between the assessments. The assessment dated July 20, 2021, was a change of condition after a hospitalization, and the next assessment should have been completed within 90 days. R4 R4's record lacked a 90-day assessment as required. R4's diagnoses included, but were not limited to, diabetes mellitus and dementia. On January 4, 2022, at 11:38 a.m. ULP-C obtained R4's blood sugar reading. R4's Resident Negotiated Service Plan with Schedule dated October 1, 2021, indicated services included assistance with transfers, bathing, dressing, grooming, blood sugar checks, and medication administration. R4's last two assessments were requested. A 90-day assessment dated August 30, 2021, and a change in condition assessment dated September 22, 2021, were provided.	01620		

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01620	Continued From page 20 On January 5, 2022, at 4:42 p.m. IHCD-A confirmed R4's record lacked any other additional assessments. IHCD-A stated staff were working on an assessment currently, and verified R4's last assessment was over 90 days ago. R2 R2's record lacked a significant change in condition assessment after a hospitalization. R2's diagnoses included but were not limited to, multiple sclerosis (a degenerative disorder that affects the central nervous system, specifically the brain and the spinal cord), hypothyroidism (condition resulting from decreased production of thyroid hormones), anxiety disorder, epilepsy (seizure disorder), neuromuscular dysfunction of the bladder (a condition in which problems with the nervous system affect the bladder and urination), and osteoporosis (condition when bone strength weakens and is susceptible to fracture). R2's Resident Negotiated Service Plan with Schedule dated August 23, 2021, indicated services included assistance with bathing, catheter cares, brace placement, and medication administration. On January 4, 2021, ULP-J stated she had completed urinary catheter (a soft hollow tube, which is passed into the bladder to drain urine) care for R2 earlier in the morning. On January 6, 2021, at 8:46 a.m. ULP-J stated she usually completed emptying and cleaning of the urinary catheter bag; however, an outside provider was scheduled to complete a catheter change today; therefore, she would not be	01620		

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01620	Continued From page 21 completing catheter cares that day. R3's last two comprehensive assessments were requested. A 14-day assessment was completed on August 23, 2021, and a 90 day assessment completed on November 15, 2021. R3's record identified she had been hospitalized September 1, 2021, through September 24, 2021. R3's record lacked evidence a change in condition assessment had been completed upon hospital return. On January 5, 2022, at 5:22 p.m. IHCD-A stated staff were to follow policy and a change in condition assessment should have been completed after R2's hospitalization. The licensee's 6.19 Resident Change in Condition or Need policy dated August 2021, identified "[the licensee] will conduct initial reviews and scheduled assessments and monitoring as required. And, when changes in condition or need are identified, a Registered Nurse will initiate a change in condition assessment. The assessment may be limited to only those issues where a change has been identified." "Change of condition assessments will also be initiated after every resident readmission to [the facility] from the hospital, emergency department or other medical/treatment stay". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01890 SS=E	144G.71 Subd. 20 Prescription drugs	01890		

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01890	Continued From page 22 A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure time sensitive medications were labeled with the date open for four of five residents (R3, R6, R7, R4) and failed to ensure medications were maintained bearing the original prescription label with legible information for one of one resident (R8) with medication storage 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, 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 January 4, 2022, at 12:00 p.m. unlicensed personnel (ULP)-B was observed to administer insulin to R3. R3's insulin was stored in a bag, inside of a cupboard in R3's apartment. In the bag, there were two NovoLog insulin pens and one Basaglar insulin pen. None of the insulin pens had a date opened or expired marked on the pens. ULP-B stated she gets the pens from	01890		

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01890	Continued From page 23 the nurse if she needs a new pen and she thought they were the ones to mark with the open date. ULP-B stated insulin pens were good for about a week. On January 4, 2022, at approximately 12:05 p.m. ULP-J stated insulin pens were good within the month. On January 4, 2022, at 12:07 p.m. licensed practical nurse (LPN)-D stated ULP were to write the date on the pen and were to only have one pen open at a time. If a new pen was needed, they got it from the nurse who has them stored in the nursing office. A review of the insulin pens with LPN-D was completed and verified with the following findings: - the findings noted above for R3; - R6 had a Levemir and Humalog pen. Neither pen was dated when it was open or when it expired. - R7's Humalog pen was not dated when it was open, or when it expired. On January 4, 2022, at approximately 10:58 a.m. the Group 3 (three) memory care locked medication cart was reviewed with ULP-C. R4's opened Humalog insulin pen lacked the date the pen had been opened, and when the pen would expire. In the top left drawer of the medication cart were two opened Flonase (allergy) nasal sprays. One of the nasal sprays was labeled for R8, the other nasal spray lacked a label. ULP-C indicated the unlabeled Flonase nasal spray was probably for R8, but was unable to verify without a label attached to the medication.	01890		

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01890	Continued From page 24 On January 4, 2022, at 11:34 a.m. licensed practical nurse (LPN)-H confirmed insulin pens should be dated when opened and verified all medications should have labels. On January 4, 2022, at 3:05 p.m. interim home care director (IHCD)-A stated all time sensitive medications should be labeled with the date they were opened and discarded, according to manufacturer recommendations. In addition all medications should have a pharmacy label which included the residents name, the name of the medication, and other information. The manufacturer instructions for Basaglar insulin dated December 5, 2019, instructed to throw away the opened Pen after 28 days, even if it still has insulin left in it. The manufacturer's instructions for NovoLog insulin dated October 22, 2021, directed to dispose after 28 days once opened. The manufacturer's instructions for Lantus insulin pens dated December 2019, directed to discard the pen 28 days after it had been opened, even if it still had insulin left in it. The manufacturer's instructions for Levemir insulin pens dated January 2019, directed to dispose of the pen after 42 days, even if there is insulin left in the pen or vial. The manufacturer's instructions for Humalog revised April 2020, noted to throw away all opened pens after 28 days of use, even if there is insulin left in it. The licensee's 7.11 Medication Storage policy dated August 2021, noted medications will be	01890		

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01890	Continued From page 25 stored consistent with manufacturer's recommendation. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21691	A. BUILDING: _____ B. WING _____	01/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROITENBERG FAMILY ASSISTED LIV	3610 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426

(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
01910	Continued From page 26	01910		

medications were given, date of disposition, and names of staff and other individuals involved in the disposition for one of one discharged resident (R1) with record review.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).

The findings include:

R1 began receiving assisted living services on August 1, 2021.

R1's Progress Notes dated November 26, 2021, at 3:22 p.m. identified "Resident was transferred to SHW TCU [facility transitional care unit]. Resident left facility at around 11:00 a.m. Resident's spouse and son here and aided with moving. Resident's medications were escorted over to the TCU with writer and handed over to the TCU nurse. Resident has enough medications to last her until followed by Hospice RN. Report passed over to nurse with no concerns."

R1's record lacked evidence of a disposition of medications.

On January 5, 2021, at 1:10 p.m. the interim home care director (IHCD)-A verified R1 had been receiving medication administration and care assistance. IHCD-A indicated R1's care needs had been increasing with hospice already

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	21691	A. BUILDING: _____ B. WING _____	01/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROITENBERG FAMILY ASSISTED LIV	3610 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426

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01910	Continued From page 27 involved, and at a care conference family decided to move R1 to a higher level of care. IHCD-A verified no disposition of medications was present for R1, and would expect nurses to complete per facility policy. The licensee's 7.23 Medication Disposal policy dated August 2021, noted: upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01910		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by:	02040		

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02040	Continued From page 28 Based on observation, record review, and interview, the licensee failed to provide a complete facility hazard vulnerability or safety risk assessment (HVA) plan to identify both hazards and mitigations on and around the property. The hazards indicated on the HVA plan must be assessed and mitigated to protect the residents from harm. This has the potential to directly affect all dementia care residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients). The findings include: On January 4, 2022, at approximately 2:30 p.m. survey staff received the HVA plan documentation, Kaiser Permanente Risk Assessment Tool-Ackerberg Campus 11-9-2021, from licensed assisted living director (LALD)-G for review. On January 4, 2022, at approximately 4:30 p.m, the review of the HVA documentation revealed the licensee lacked all the content of the required hazard vulnerability assessment to specifically include documented mitigations (safety measures) to protect residents from potential harm as part of the HVA plan. On January 4, 2022, at approximately 5:00 p.m. survey staff explained to licensed assisted living director (LALD)-G and the Operations Project	02040		

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02040	Continued From page 29 Coordinator that the licensee was required to develop a complete HVA plan that included mitigations. An HVA plan documentation must have contents of potential hazards identified, assessed, and mitigated specific to each hazard vulnerability on and around the licensee's property to protect the dementia residents from harm. Hazard vulnerabilities such as resident elopement must be assessed and mitigated to protect residents from potential harm. Reduction of the risk of elopement from exit doors that deactivate during a fire emergency, any delayed egress doors, or electronic keyboard failure leading to bypass that may pose risks to residents leaving the secured area into the outdoors during subzero degree weather. All potential hazards on and around the property must also be assessed and mitigated in the HVA plan. LALD-G acknowledged the findings. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	02040		
02110 SS=E	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans,	02110		

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	21691	A. BUILDING: _____ B. WING _____	01/06/2022

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02110	Continued From page 30 including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living facility with dementia care provided the required policies and procedures to three of four residents (R3, R4, R5) with records reviewed. 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 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	02110		

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02110	Continued From page 31 occurred repeatedly, but is not found to be pervasive). The findings included: R3, R4, and R5's records included no documentation for receipt of required policies and procedures to be provided at the time of resident move-in to the facility. On January 5, 2022, at 12:00 p.m. licensed assisted living director (LALD)-G stated all resident records should include a confirmation signature page for dementia policies and staff training as per facility policy. The licensee's Assisted Living with Dementia Care Additional Required Policies dated September 3, 2021, identified "Because [the facility] has an Assisted Living with Dementia Care license, in addition to the policies and procedures required for the facility written policies and procedures must address the following list". "In addition, these policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. The policies can be provided in electronic format if desired." -"Philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; -Evaluation of behavioral symptoms and design of supports for intervention plans, including non-pharmacological practices that are person-centered and evidence-informed; -Wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; -Medication management, including an	02110		

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02110	Continued From page 32 assessment of residents for the use and effects of medications, including psychotropic medications; -Staff training specific to dementia care; -Description of life enrichment programs and how activities are implemented; -Description of family support programs and efforts to keep the family engaged; -Limiting the use of public address and intercom systems for emergencies and evacuation drills only; -Transportation coordination and assistance to and from outside medical appointments; -Safekeeping of residents' possessions." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		

Minnesota Department of Health
Division of Environmental Health, FPLS
PO Box 64975
Saint Paul, 55164-0975
651-201-4500

Type: Full
Date: *01/04/22*
Time: 13:16:58
Report: 1023221001

Food and Beverage Establishment Inspection Report

Location:
Roitenberg Family Assisted Liv
3610 Phillips Parkway South
St Louis Park, MN55426
Hennepin County, 27

Establishment Info:
ID #: 0038297
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9529081700
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.

OPERATOR STATED NO EMPLOYEE ILLNESS LOG WAS AVAILABLE FOR REVIEW. SENT SAMPLE ILLNESS LOG TO OPERATOR.

Comply By: 01/04/22

3-200A Food Characteristics: approved source

3-201.11A ** Priority 1 **

MN Rule 4626.0130A Remove all foods not obtained from approved sources from the premises.

OPERATOR STATED UNPASTEURIZED RAW SHELL EGGS BEING STORED IN 3RD FLOOR REACH IN COOLER WERE NOT PART OF THE NORMAL FOOD SERVICE OPERATIONS AND DID NOT KNOW WHERE THEY CAME FROM. OPERATOR DISCARDED EGGS. *CORRECTED ON SITE

Comply By: 01/04/22

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 RAW SHELL EGGS BEING STORED ABOVE RTE FOODS IN 3RD FLOOR REACH IN COOLER. RAW ANIMAL PRODUCTS MUST ALWAYS BE STORED BELOW RTE FOODS. OPERATOR DISCARDED EGGS. *CORRECTED ON SITE

Comply By: 01/04/22

2-100 Supervision

2-102.12AMN

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

NO CFPM EMPLOYED AT THIS FACILITY. TO GET THE CFPM YOU MUST TAKE A FOOD MANAGER SAFETY CLASS, PASS THE TEST, AND REGISTER WITH MDH. INITIAL CFPM APPLICATION SENT TO OPERATOR.

Comply By: 01/04/22

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

3RD FLOOR JUICE MACHINE NOT KEEPING FOODS COLD. REPAIR OR REPLACE MACHINE SO THAT IT MAINTAINS SAFE FOOD TEMPERATURES.
3RD FLOOR REACH IN FREEZER BROKEN - REPAIR OR REPLACE. 4TH FLOOR DISH MACHINE BROKEN - REPAIR OR REPLACE.

Comply By: 01/04/22

Food and Equipment Temperatures

Process/Item: Cold Hold/JUICE
Temperature: 84 Degrees Fahrenheit - Location: JUICE MACHINE 3RD FLOOR
Violation Issued: Yes

Process/Item: Cold Hold/CREAM CHEESE
Temperature: 39 Degrees Fahrenheit - Location: REACH IN COOLER 3RD FLOOR
Violation Issued: No

Process/Item: Cold Hold/BUTTER
Temperature: 41 Degrees Fahrenheit - Location: REACH IN COOLER 4TH FLOOR
Violation Issued: No

Process/Item: Cold Hold/JUICE
Temperature: 40 Degrees Fahrenheit - Location: JUICE MACHINE 4TH FLOOR
Violation Issued: No

Process/Item: Cold Hold/CREAM CHEESE
Temperature: 41 Degrees Fahrenheit - Location: REACH IN COOLER 2ND FLOOR
Violation Issued: No

Process/Item: Cold Hold/JUICE
Temperature: 40 Degrees Fahrenheit - Location: JUICE MACHINE 2ND FLOOR
Violation Issued: No

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

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. SURVEYORS FROM HRD WERE STACY HAAG AND SUSAN KALIS. INSPECTION CONDUCTED IN PRESENCE OF CHRIS CHURCH AND LISA HAKANSON, THE FACILITY PERSONS IN CHARGE, AS WELL AS PEGGY SPADAFORE (FPLS SANITARIAN). ALL

Food and Beverage Establishment Inspection Report

VIOLATIONS WERE DISCUSSED WITH PERSONS IN CHARGE AND HRD EVALUATOR DURING INSPECTION.

AT TIME OF INSPECTION KITCHEN WAS BEING REMODELED AND FOOD WAS BEING CATERED IN FROM ASSOCIATED NURSING HOME. FOOD SAFETY PROCEDURES AND PRACTICES WERE DISCUSSED IN DETAIL. ACTIVITY KITCHENS ON 2ND, 3RD, AND 4TH FLOORS WERE OPERATIONAL AND INSPECTED.

THESE ADDITIONAL TOPICS WERE DISCUSSED WITH THE PERSON IN CHARGE:
- EMPLOYEE ILLNESS EXCLUSION
- HAND WASHING PROCEDURE
- NO BARE HAND CONTACT WITH RTE FOOD
- VOMIT CLEAN UP PROCEDURE
- SERVING HIGH RISK POPULATIONS
- COOKING ROASTS FOR SPECIAL OCCASIONS

DOCUMENTS ON THE FOLLOWING TOPICS WERE INCLUDED WITH INSPECTION REPORT:
- EMPLOYEE ILLNESS TRACKING
- SAMPLE VOMIT CLEAN UP PROCEDURE
- SAMPLE HANDWASHING SIGN
- HIGH RISK POPULATION REQUIREMENTS
- APPROVED TIMES/TEMPERATURES FOR COOKING ROASTS

FOR CORRECT BY DATES REFER TO COMPLETE REPORT ISSUED BY HRD.

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 1023221001 of 01/04/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
CHRIS CHURCH
PERSON IN CHARGE

Signed: Gregory T Nelson
Gregory T. Nelson
Public Health Sanitarian
Freeman Building
651-201-4259
greg.nelson@state.mn.us