Electronically Delivered

April 10, 2025

Licensee
Minn Care Home Health
7055 Perry Avenue North
Brooklyn Center, MN 55429

RE: Project Number(s) SL37065016

Dear Licensee:

On March 12, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the December 19, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Renee L. Anderson

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

JMD

Electronically Delivered

February 11, 2025

Licensee
Minn Care Home Health
7055 Perry Avenue North
Brooklyn Center, MN 55429

RE: Project Number(s) SL37065016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 19, 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.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00

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

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

The correction order documentation should include the following:

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

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

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

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

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

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

the website listed above.

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

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

If you have any questions, please contact me.

Sincerely,

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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37065	A. BUILDING: _____ B. WING _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINN CARE HOME HEALTH	7055 PERRY AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL37065016-0 On December 16, 2024, through December 19, 2024, 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 five (5) residents; five receiving services under the provider's Assisted Living license. An immediate correction order was identified on December 17, 2024, issued for SL37065016-0, tag identification 2310. During the course of the survey, the licensee took action to mitigate the imminent risk; the scope and level remain unchanged. An immediate correction order was identified on December 18, 2024, issued for SL37065016-0, tag identification 0780.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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0 000	Continued From page 1 During the course of the survey, the licensee took action to mitigate the imminent risk. Noncompliance remained and the scope and level remain unchanged.	0 000		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage;	0 480		

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0 480	Continued From page 2 (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include:	0 480		

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0 480	Continued From page 3 Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated December 17, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the required information related to the grievance procedure including the telephone number, email contact, and contact information for the individuals who are responsible for handling resident grievances,	0 550		

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0 550	Continued From page 4 the Office of Ombudsman for Long-Term Care (OOLTC) and Mental Health and Developmental Disabilities (OMHDD), as well as information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). This had the potential to affect all of the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or 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: On December 16, 2024, at 10:50 a.m., during a facility tour, the surveyor observed the entry area and common areas, and noted there was a posting of the grievance procedure, located on a bulletin board, in the common area of the facility. The posted grievance procedure lacked the telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. In addition, the posted procedure lacked the contact information for the OOLTC and the OMHDD, or any information for reporting suspected maltreatment to MAARC. On December 16, 2024, at 11:00 a.m., licensed assisted living director (LALD)-A stated the required content noted above was not currently posted as required. LALD-A further stated he was unaware the posted grievance procedure did not have all the required information on it.	0 550		

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0 550	Continued From page 5 The licensee's Grievance policy dated August 1, 2019, lacked direction to post the above information as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included baseline testing for two of two employees (clinical nurse supervisor (CNS)-C,	0 660		

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0 660	Continued From page 6 unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's Facility TB Risk Assessment dated January 1, 2024, indicated the facility was a low risk setting for TB transmission. CNS-C was hired October 7, 2020, and provided supervision to direct care staff and direct care services for residents of the facility. CNS-C's employee record included a TB history and symptom screening form completed, October 5, 2020, and a QuantiFERON TB Gold Plus blood test dated March 16, 2020, which was greater than ninety-days prior to CNS-C's hire date. ULP-D was hired November 2, 2023, and provided direct cares for residents of the facility. ULP-D's employee record included a TB history and symptom screening form completed October 24, 2023, and a negative TB first-step skin test dated October 27, 2023. ULP-C's employee record lacked documentation of the result of a second-step TB skin test or blood test result. On December 18, 2024, at 11:03 a.m., licensed assisted living director (LALD)-A stated they	0 660		

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0 660	Continued From page 7 normally screen employees upon hire; however, if a new employee has had a TB test within the past year licensee would not require an employee to complete TB testing, and would accept that result. The Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, noted, "Baseline TB screening consists of three components: 1. Assessing for current symptoms of active TB disease; 2. Assessing TB history; 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single IGRA; and An employee may begin working with patients after a negative TB symptom screen (i.e., no symptoms of active TB disease) and a negative IGRA or TST (i.e., first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients." The licensee's Tuberculosis and Staff Screening policy, dated August 15, 2021, indicated Staff of the licensee whose essential job functions require work within the same air space of home care clients would be screened and tested for tuberculosis prior to the staff being exposed to clients. Baseline (upon hire) screening shall be completed, but serial (annual) screening would only be required with increased occupational risk or exposure, or for any Minn Care health care personnel that have an untreated Latent Tuberculosis Infection (LTBI). Furthermore, the policy indicated screening would be conducted as follows:	0 660		

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0 660	Continued From page 8 1. New staff would be screened for active signs of TB using the Baseline TB Screening Tool for HCWs. 2. New staff would have an IGRA blood test or a two-step Mantoux conducted with results documented on the Baseline TB Screening Tool for HCWs. 3. No staff would be permitted to begin work where the work involves sharing the air space with residents until the negative results of the first Mantoux are read and documented or a negative IGRA blood test result is received and documented. 4. Staff TB screening results would be kept in each employee medical file. 5. Staff would be screened for signs and symptoms on an annual basis. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and	0 680		

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0 680	Continued From page 9 (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency disaster plan with all required content. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: The licensee's Emergency Preparedness (EP) plan dated January 1, 2024, lacked the following required content: - a communication plan that included: - names and contact information for staff, resident physicians, other facilities, volunteers; - contact information for federal, state, tribal, local EP staff, ombudsman;	0 680		

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0 680	Continued From page 10 - EP training and testing program; - EP training program for staff (including documentation of training provided); and - EP testing/annual testing requirements. On December 16, 2024, at 1:24 p.m., during a telephone interview, executive director (ED)-B stated the EP plan was updated on January 1, 2024, however, he was not aware of all the required content. Moreover, ED-B stated licensee had not posted a disaster plan prominently within the facility as required. The licensee's Disaster Planning and Emergency Preparedness policy dated October 1, 2021, indicated licensee would have in place a written emergency and disaster plan, signage, directions, training, and drills to facilitate the management of resident's care and services in response to a natural disaster or other emergencies. The emergency disaster plan would be posted in the kitchen cabinet (prominently in the building) and be available to emergency responders. Furthermore, the licensee's EP procedures would include: - conducting disaster drills at least every six months; - reviewing emergency evacuation procedures; - reviewing fire procedures; and - emergency and disaster training annually to residents. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=I	144G.45 Subd. 2 (a) (1) Fire protection and physical environment	0 780		

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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
0 780	Continued From page 11 for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life and failed to keep the facility in compliance with the Minnesota Fire Code. This had the potential to directly affect all of the residents and staff. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was	0 780	During the course of the survey, the licensee took action to mitigate the imminent risk. Noncompliance remained and the scope and level remain unchanged.	

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	37065	A. BUILDING: _____ B. WING _____	12/19/2024

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0 780	Continued From page 12 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 a facility tour on December 18, 2024, from 1:30 p.m. to 3:30 p.m., with licensed assisted living director (LALD)-A, it was observed that compliant emergency escape and rescue openings were not provided in resident sleeping rooms 1, 2 and 3. OCCUPIED RESIDENT SLEEPING ROOMS Resident sleeping room 1, emergency escape and rescue clear window opening measurements were 35 inches wide, 17.6 inches in height and only 616 square inches in openable area. The window was measured with LALD-A, and the surveyor present. The window did not meet the minimum requirements for total clear opening square inch area. Resident sleeping room 2, emergency escape and rescue clear window opening measurements were 27 inches wide, 15.6 inches in height and only 421 square inches in openable area. The window was measured with LALD-A, and the surveyor present. The window did not meet the minimum requirements for total clear opening square inch area. Resident sleeping room 3, emergency escape and rescue clear window opening measurements were 35 inches wide, 15.75 inches in height and only 546 square inches in openable area. The window was measured with LALD-A, and the surveyor present. The window did not meet the	0 780		

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0 780	Continued From page 13 minimum requirements for total clear opening square inch area. It was explained to LALD-A, that at least one compliant emergency escape and rescue opening is required within each resident sleeping room. Existing emergency escape and rescue openings are required to meet a minimum clear opening area of 648 square inches and have a minimum dimension of 20 inches in height and a minimum dimension of 20 inches in width. Windowsill height shall not be more than 48 inches from the floor to the clear opening. These deficient conditions were visually verified by LALD-A, accompanying on the tour. Survey staff explained that an immediate correction order was issued for the above findings. TIME PERIOD FOR CORRECTION: Immediate On the same facility tour with LALD-A., the surveyor made the following observations of non-compliance with current Minnesota Fire Code provisions. Resident rooms required to have multiple smoke alarms are required to have interconnected alarms so activation of one alarm activates all alarms within the dwelling/sleeping unit. During the tour the smoke alarms were tested, and LALD-A verified the smoke alarms were not interconnected so activation of one alarm activates all alarms throughout the facility. In resident room 5, there were used cigarette butts on combustible furniture and in homemade ash tray next to the bed, occupant stated they	0 780		

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0 780	Continued From page 14 were saving them for later. LALD-A stated used cigarettes are not allowed back into the facility. There was an appropriate cigarette butt disposal container located out the back door. Used cigarette butts are required to be discarded in the appropriate disposal container in accordance with the facility smoking policy. Combustible storage under the basement stairs in the laundry room. Combustible materials shall not be stored in exits or enclosures for stairways and ramps. These deficient conditions were visually verified by LALD-A accompanying on the tour. On December 18, 2024, at 2:30 p.m., LALD-A stated they understand the safety deficiencies TIME PERIOD FOR CORRECTION: Two (2) days During the course of the survey, the licensee provided corrective documentation on action taken to mitigate the imminent risk to residents identified in the immediate order. Noncompliance remained and the scope and level remain unchanged.	0 780		
0 800 SS=C	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and	0 800		

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0 800	Continued From page 15 repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain 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. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings inlude: On a facility tour on December 18, 2024, from 1:30 p.m. to 3:30 p.m., with licensed assisted living director (LALD)-A, the following was observed: The basement bathroom, toilet paper holding assembly arm was no longer connected to the wall. This could allow the wall to deteriorate faster and allow further damage to occur. Main level wall near resident room two, had a section of the wood paneling wall missing and was filled with chalk. Hole was shoulder height and could allow equipment or clothing to get	0 800		

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0 800	Continued From page 16 caught. On December 18, 2024, at 2:30 p.m., LALD-A stated they understood the above-listed deficiencies. 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) staff 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) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill	0 810		

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0 810	Continued From page 17 every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. 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 the residents). The findings include: On a facility tour on December 18, 2024, from 1:30 p.m. to 3:30 p.m., with licensed assisted living director (LALD)-A; surveyor observed the posted evacuation plans lacked identification of resident room identifiers. Fire evacuation diagrams did not include the resident rooms and areas of the basement to include room identifiers. Exit plan diagrams must be correctly labeled to reduce confusion and potential obstructions to egress in a fire or similar emergency. On December 18, 2024, LALD-A provided	0 810		

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0 810	Continued From page 18 documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "Minn Care Home Health", dated January 2020, failed to include the following: 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 plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but the plan was designed for a building with life safety systems such as fire doors and smoke compartments. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. LALD-A lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. LALD stated that he verbally does training at time of hire. No other training documentation was provided. On December 18, 2024, at 2:30 p.m., LALD-A stated they understood the requirements for training residents and staff and would implement a training program that was compliant with statute requirements. DRILLS:	0 810		

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0 810	Continued From page 19 The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Record review of licensee's evacuation drill log, indicated evacuation drills were conducted on April 28, 2024, and October 28, 2024. No other documentation was provided. On December 18, 2024, at 2:30 p.m., LALD-A stated there were no additional documented drills for the facility. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 900 SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37.	0 900		

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0 900	Continued From page 20 (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and execute a written assisted living contract with the required content for two of four residents (R4, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R4 was admitted December 5, 2024. R4's service plan dated June 30, 2023, was created by R4's discharging facility, but remained in use by the licensee. The service plan indicated R4 received services including assistance with appointment reminders, bathing assistance, behavioral management, grooming, safety checks, meal assistance, shopping assistance, socialization, and medication administration. R5 was admitted December 4, 2024.	0 900		

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0 900	Continued From page 21 R5's service plan dated April 19, 2023, was created by R5's discharging facility, but remained in use by the licensee. The service plan indicated R5 received services including assistance with ADLs, catheter care, colostomy care, transfers, behavior management, and medication management. R4 and R5's records lacked a written contract which included all of the terms concerning the provisions of the following as required: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. The licensee lacked evidence they provided the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract. On December 16, 2024, at 12:25 p.m., licensed assisted living director (LALD)-A stated licensee lacked contracts for R4 and R5. LALD-A further stated R4 and R5 were transferred to licensee from their sister community, for a temporary relocation, due to renovations being completed at their sister location. Moreover, stated R4 and R5 were never discharged from their sister community, and therefore, the contract that had been developed at the sister facility was the contract the licensee had been using. The licensee did not provide a policy related to developing, maintaining, and executing a written contract with the residents. No further information was provided.	0 900		

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0 900	Continued From page 22 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 900		
01620 SS=D	144G.70 Subd. 2 (c-e) 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 interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment, not to exceed 90 calendar days from the date of the previous assessment for one of four residents (R3).	01620		

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01620	Continued From page 23 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: R3 was admitted November 30, 2021, and had diagnoses to include but not limited to chronic combined systolic (congestive) and diastolic (congestive) heart failure, major depressive disorder, morbid (severe) obesity, and type 2 diabetes mellitus. R3's record included documentation of an RN reassessment completed February 6, 2024, and a subsequent assessment completed August 28, 2024, greater than 90 days later (204 days). The next RN assessment was completed November 27, 2024, greater than 90 days after the previous assessment (91 days). On December 17, 2024, at 2:07 p.m., licensed assisted living director (LALD)-A stated the 90-day reassessment may have escaped the RN's mind or it had been misplaced on the One Drive (electronic record system). The licensee's Service Plans policy dated January 1, 2020, indicated the RN would conduct an initial assessment within five days after initiation of home care services, resident monitoring and reassessment would be conducted no more than 14 days after initiation of	01620		

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01620	Continued From page 24 services, and ongoing resident monitoring and reassessment would be conducted as needed based on changes in the needs of the resident and would not exceed 90 days from the last date of the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced	01640		

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01640	Continued From page 25 by: Based on interview and record review, the licensee failed to finalize a current written service plan, including a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided for two of two residents (R4 and R5). 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: R4 R4 was admitted to the facility on December 5, 2024. R4's diagnoses included but not limited to fibromyalgia, generalized anxiety disorder, anemia, post-traumatic stress disorder, and primary hypertension. R4's service plan dated June 30, 2023, was created by R4's discharging facility, but remained in use by the licensee. The service plan indicated R4 received services including assistance with appointment reminders, bathing assistance, behavioral management, grooming, safety checks, meal assistance, shopping assistance, socialization, and medication administration. R4's record lacked an initial service plan. R5	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37065	A. BUILDING: _____ B. WING _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINN CARE HOME HEALTH	7055 PERRY AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01640	Continued From page 26 R5 was admitted to the facility on December 4, 2024. R5's diagnoses included but not limited to stage 4 decubitus ulcer of sacral region, stage 2 pressure ulcer of right heel, paraplegia, and diabetes mellitus type 2. R5's service plan dated April 19, 2023, was created by R5's discharging facility, but remained in use by the licensee. The service plan indicated R5 received services including assistance with ADLs, catheter care, colostomy care, transfers, behavior management, and medication management. R5's record lacked an initial service plan. On December 16, 2024, at 12:19 p.m., licensed assisted living director (LALD)-A stated R4 and R5 were transferred to the licensee from their sister community, for a temporary relocation, due to renovations being completed at their sister location. LALD-A further stated R4 and R5 were never discharged from their sister community, and therefore, the service plan that had been developed at the sister facility was the service plan the licensee had been using. The licensee's Service Plans policy dated January 1, 2020, indicated all services provided to licensee's residents would be delivered after an assessment by a registered nurse (RN) was completed, and an up-to date service plan had been signed by a RN, and the resident or the resident's designated representative, documenting agreement on the services being provided. No further information was provided.	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37065	A. BUILDING: _____ B. WING _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINN CARE HOME HEALTH	7055 PERRY AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01640	Continued From page 27 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care standards, medical or nursing standards for two of two residents (R3, R5) who utilized bed rails. This resulted in issuance of an immediate correction order on December 17, 2024. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 16, 2024, at approximately 12:35 p.m., the surveyor observed R3 and R5's beds, which included bilateral, upper half, hospital-style bedrails. All rails were observed in the raised	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37065	A. BUILDING: _____ B. WING _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINN CARE HOME HEALTH	7055 PERRY AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 28 position. R3 R3's diagnoses included but not limited to congestive heart failure, severe obesity, major depressive disorder, obstructive sleep apnea, hypertensive heart disease, and diabetes mellitus type 2. R3's service plan dated July 27, 2022, indicated R3 received services including assistance with activities of daily living (ADLs), transfers, behavior management, and medication management. R3's registered nurse (RN) assessment dated November 27, 2024, indicated bed rails met Food and Drug Administration (FDA) guidelines. The assessment lacked documentation of the measurments of the FDA-identified entrapment zones. R3's record lacked documentation the licensee provided education including the risks versus benefits of using bedrails to R3 or their representative. R5 R5's diagnoses included but not limited to stage 4 decubitus ulcer of sacral region, stage 2 pressure ulcer of right heel, paraplegia, and diabetes mellitus type 2. R5's service plan dated April 19, 2023, was created by R5's discharging facility, but remained in use by the licensee. The service plan indicated R5 received services including assistance with ADLs, catheter care, colostomy care, transfers, behavior management, and medication management.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37065	A. BUILDING: _____ B. WING _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINN CARE HOME HEALTH	7055 PERRY AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 29 R5's initial RN assessment dated December 4, 2024, indicated bed rails had been appropriate based on assessed need. The assessment lacked documentation of the measurments of the FDA-identified entrapment zones. R5's record lacked documentation the licensee provided education including the risks versus benefits of using bedrails to R5 or their representative. On December 17, 2024, at 10:19 a.m., clinical nurse supervisor (CNS)-C stated the bedrails had not been assessed for safety with measurements, nor was the education provided to the resident/resident representative on the risks associated with bed rail use documented. CNS-C further stated because it had been the residents' home, the residents had the right to use side rails; however, he was unaware side rail assessments and hospital bed zone measurements were requirements. The FDA, "A Guide to Bed Safety," revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." On December 17, 2024, at approximately 10:25 a.m., the licensee's Siderails policy requested; however, Licensed Assisted Living Director	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37065	A. BUILDING: _____ B. WING _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINN CARE HOME HEALTH	7055 PERRY AVENUE NORTH BROOKLYN CENTER, MN 55429

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02310	Continued From page 30 (LALD)-A stated licensee had no side rail policy available. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate The licensee provided corrective documentation on action taken to mitigate the imminent risk to residents identified in the immediate order. Noncompliance remained and the scope and level remain unchanged.	02310		

Minnesota Department of Health

625 Robert Street North
St Paul
651-201-4500

Type: Full
Date: *12/17/24*
Time: 11:32:27
Report: 7994241239

Food and Beverage Establishment Inspection Report

Location:
Minn Care Home Health
7055 Perry Avenue North
Brooklyn Center, MN55429
Hennepin County, 27

Establishment Info:
ID #: 0038509
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7632006270
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.

5-200C Plumbing: Maintenance, fixture location

5-205.11AB ***** Priority 2 *****

MN Rule 4626.1110AB The handwashing sink must be accessible at all times for employee use, and must be used only for handwashing.

HANDWASH SINK WAS FOUND WITH THAWING MILK JUG IN IT. ENSURE THIS SINK IS ONLY USED FOR HANDWASHING.

Comply By: 12/17/24

2-100 Supervision

2-102.12AMN

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

CURRENTLY THERE IS ONLY ONE CFPM FOR THREE HOMES. ENSURE ONE IS PROVIDED FOR EVERY TWO HOUSES.

Comply By: 12/17/24

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

INSPECTION CONDUCTED IN THE PRESENCE OF HRD STAFF AND FINDINGS SHARED AT THE END OF INSPECTION.

WILL EMAIL SUPPORTING DOCUMENTS AND LINKS TO HRD STAFF AT THE END OF THE DAY.

KITCHEN IS RESIDENTIAL AND FOOD IS PREPARED FOR SAME DAY SERVICE.

FLOOR IS CERAMIC TILE, CABINETS ARE WOOD WITH HALLOWED ENCLOSED BASES,

Food and Beverage Establishment Inspection Report

GRANITE COUNTER TOPS AND POPCORN TEXTURED CEILING. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT ANY TIME THERE IS FOUND TO BE A RISK OF CONTAMINATION OR CONCERN THE PHYSICAL FACILITIES WILL BE REQUIRED TO BE BROUGHT UP TO CODE.

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 7994241239 of 12/17/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: _/_/_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Establishment Representative

Signed: Crystal Elva
Crystal Elva
Public Health Sanitarian 3
St Paul
651-201-3981
Crystal.Elva@state.mn.us

Report #: 7994241239

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health

625 Robert Street North
St Paul

No. of RF/PHI Categories Out	2
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 12/17/24
Time In 11:32:27
Time Out

Minn Care Home Health	**Address** 7055 Perry Avenue North	**City/State** Brooklyn Center, MN	**Zip Code** 55429	**Telephone** 7632006270
License/Permit # 0038509	**Permit Holder**	**Purpose of Inspection** Full	**Est Type**	**Risk Category**

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

Compliance Status					COS	R
Supervision						
1	(IN)	OUT		PIC knowledgeable; duties & oversight		
2	IN	(OUT)	N/A	Certified food protection manager, duties		
Employee Health						
3	(IN)	OUT		Mgmt/Staff;knowledge,responsibilities&reporting		
4	(IN)	OUT		Proper use of reporting, restriction & exclusion		
5	(IN)	OUT		Procedures for responding to vomiting & diarrheal events		
Good Hygenic Practices						
6	(IN)	OUT	N/O	Proper eating, tasting, drinking, or tobacco use		
7	(IN)	OUT	N/O	No discharge from eyes, nose, & mouth		
Preventing Contamination by Hands						
8	(IN)	OUT	N/O	Hands clean & properly washed		
9	IN	OUT	N/A (N/O)	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	IN	(OUT)		Adequate handwashing sinks supplied/accessible		
Approved Source						
11	(IN)	OUT		Food obtained from approved source		
12	IN	OUT	N/A (N/O)	Food received at proper temperature		
13	(IN)	OUT		Food in good condition, safe, & unadulterated		
14	IN	OUT	(N/A) N/O	Required records available; shellstock tags, parasite destruction		
Protection from Contamination						
15	(IN)	OUT	N/A N/O	Food separated and protected		
16	(IN)	OUT	N/A	Food contact surfaces: cleaned & sanitized		
17	(IN)	OUT		Proper disposition of returned, previously served, reconditioned, & unsafe food		

Compliance Status					COS	R
Time/Temperature Control for Safety						
18	IN	OUT	N/A	(N/O) Proper cooking time & temperature		
19	IN	OUT	(N/A)	N/O Proper reheating procedures for hot holding		
20	IN	OUT	N/A	(N/O) Proper cooling time & temperature		
21	IN	OUT	(N/A)	N/O Proper hot holding temperatures		
22	(IN)	OUT	N/A	Proper cold holding temperatures		
23	(IN)	OUT	N/A	N/O Proper date marking & disposition		
24	IN	OUT	(N/A)	N/O Time as a public health control: procedures & records		
Consumer Advisory						
25	IN	OUT	(N/A)	Consumer advisory provided for raw/undercooked food		
Highly Susceptible Populations						
26	IN	OUT	(N/A)	Pasteurized foods used; prohibited foods not offered		
Food and Color Additives and Toxic Substances						
27	IN	OUT	(N/A)	Food additives: approved & properly used		
28	(IN)	OUT		Toxic substances properly identified, stored, & used		
Conformance with Approved Procedures						
29	IN	OUT	(N/A)	Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
Safe Food and Water				
30	IN OUT (N/A)	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT (N/A)	Variance obtained for specialized processing methods		
Food Temperature Control				
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT (N/A) N/O	Plant food properly cooked for hot holding		
35	(IN) OUT N/A N/O	Approved thawing methods used		
36		Thermometers provided & accurate		
Food Identification				
37		Food properly labled; original container		
Prevention of Food Contamination				
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
Proper Use of Utensils				
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
Utensil Equipment and Vending				
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 12/17/24

Inspector (Signature) Crystal Elva