Electronically Delivered

January 12, 2024

Licensee
Motivate Home Services
14673 Cimarron Avenue West
Rosemount, MN 55068

RE: Project Number(s) SL27280015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 19, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the 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.

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

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

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

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

If you have any questions, please contact me.

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27280	A. BUILDING: _____ B. WING _____	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTIVATE HOME SERVICES	14673 CIMARRON AVENUE WEST ROSEMOUNT, MN 55068

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0 000	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: SL27280015 On December 18, 2023, through December 19, 2023, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were four residents; all of whome were receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with	0 780		

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

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0 780	Continued From page 2 of the residents). The findings include: On December 18, 2023, at 11:00 a.m., survey staff toured the home with the licensed assisted living director LALD-(A). During the tour, survey staff observed that when smoke alarms were tested in resident bedrooms, outside the bedrooms, and in the basement, the other smoke alarms installed in the dwelling unit were not activated. The smoke alarms were not interconnected as required by statute. LALD-A confirmed that the smoke alarms were not interconnected at the time of the facility tour. During an interview with survey staff on December 19, 2023, at 3:00 p.m., LALD-A explained that the licensee was aware of the smoke alarm interconnection requirement but had not completed the interconnection at this location yet. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and	0 790		

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0 790	Continued From page 3 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers as required by statute. This deficient condition had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On December 18, 2023, at 11:00 a.m., survey staff toured the home with the licensed assisted living director LALD-(A). During the tour, survey staff observed that the back of the tag was blank on the fire extinguisher installed in the basement. LALD-A confirmed that monthly inspections had not been recorded on the tag at the time of the facility tour. During an interview with survey staff on December 19, 2023, at 3:00 p.m., LALD-A explained that the employees had forgotten to complete the monthly fire extinguisher inspections on the basement fire extinguisher. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		

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0 800	Continued From page 4	0 800		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On December 18, 2023, at 11:00 a.m., survey staff toured the home with the licensed assisted living director LALD-(A). During the tour, survey staff observed the following: 1. When the egress windows in occupied resident bedrooms 3 and 4 were opened and measured, the open width measured 19.75 inches. The	0 800		

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0 800	Continued From page 5 egress windows in these bedrooms did not meet the minimum window opening width of at least 20 inches. LALD-A noted that blocks had been screwed into the tracks of these windows, preventing the windows from opening fully. The blocks were removed, and the windows remeasured. Both windows measured 20.25 inches in width. This deficient condition was corrected while the nurse evaluator was still onsite. 2. The egress window in occupied resident bedroom 4 was sticking, making it difficult to open. LALD-A confirmed that the egress window was sticking at the time of the facility tour and stated that it required maintenance. 3. The battery-operated smoke alarm installed in the hallway outside resident bedrooms 3 and 4 did not work when tested. LALD-A confirmed that the smoke alarm was not working at the time of the facility tour. 4. One light bulb was not working in the light fixture above the sink vanity in a shared resident bathroom. During an interview with survey staff on December 19, 2023, at 3:00 p.m., LALD-A stated that it was a bad light bulb and not a problem with the light fixture. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of	0 810		

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0 810	Continued From page 6 a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to develop a fire safety and evacuation plan with the required content, and provide 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	0 810		

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0 810	Continued From page 7 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the facility tour, survey staff observed that posted floor plans did not identify the resident room numbers. The room used as an office was not labeled. The floor plans do not accurately identify the layout of the facility. During an interview with survey staff on December 19, 2023, at 3:00 p.m., LALD-A confirmed that the floor plans required revision. On December 19 and 20, 2023, the licensee provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and employee evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The FSEP documents failed to include 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 plans were limited to directing employees to call for assistance, assisting residents as needed with mobility out of the home, and then bringing residents to a safe location (mailbox or end of the driveway). The FSEP documents failed to include fire protection procedures necessary for residents evident by no procedures in the plan. During an interview with survey staff on December 19, 2023, at 3:00 p.m., LALD-A confirmed that the plan lacked sufficient procedures. LALD-A explained that the facility was previously regulated by the county and the requirements were different. TRAINING Record review indicated that the licensee failed to provide training to employees on the facility FSEP	0 810		

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0 810	Continued From page 8 upon hire and/or at least twice per year as evident by the lack of training documentation. The licensee explained in emails received on December 19 and 20, 2023, that employees were trained on fire safety and evacuation at the time of hire and then again, each year with a nurse. It was explained that employees also received fire safety training once a year from Educare. DRILLS Record review indicated that the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month as evident by drill logs lacking the required documentation. Monthly drills for fire and weather had been documented, but the time or shift of the drill had not been recorded. One staff signature was recorded for each drill, but the names of the employees who had participated were not documented. Some of the staff signatures did not include the person's first and last name. During an interview with survey staff on December 19, 2023, at 3:00 p.m., LALD-A explained that the facility was previously regulated by the county and the requirements were different. LALD-A stated that the facility was still using the drill logs from the county which did not include all the information MDH had requested. LALD-A stated that the licensee was working on meeting the statute requirements for employee training and evacuation drills. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent	01060		

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01060	Continued From page 9 risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and	01060		

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01060	Continued From page 10 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation for the licensee's one resident (R1) who had a hospitalization. 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: R1 started receiving services on August 15, 2023. R1's service plan last updated on August 31, 2023, indicated R1 received assistance with activities of daily living (ADLs) and medication administration. R1 was hospitalized on August 18, 2023, for behavior management. R1 was discharged from the hospital on November 2, 2023. R1's record lacked evidence of a written notice provided to the resident, the residents' legal representative, and designated representative that contained, at a minimum: - the reason for the relocation. - the name and contact information for the location to which the resident had been relocated and any new service provider.	01060		

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01060	Continued From page 11 - contact information for the Office of Ombudsman for Long-Term Care (OOLTC). - if known and applicable, the approximate date or range of dates within which the resident was expected to return to the facility, or a statement that a return date was not currently known; and a statement that, if the facility refused to provide housing or services after a relocation, the resident had the right to appeal and the contact information for the agency to which the resident may submit an appeal. R1's record lacked notification to the Office of Ombudsman for Long-Term Care that the resident had been relocated and had not returned to the facility within four days. On December 18, 2023, at 2:15 p.m. director of nursing (DON)-B stated R1's record did not have evidence the ombudsman was notified of the emergency relocation. DON-B stated she was not aware of the requirement and thought the regulation was related to termination of services only. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date	01760		

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01760	Continued From page 12 and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered according to manufacturer instructions for one of one resident (R2) receiving insulin. 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: R2's diagnoses included anxiety, hypertension, and diabetes. R2's medication administration record (MAR) dated December 2023, included the following medications: Acetaminophen 500 milligrams(mg) (used for pain control) Aripiprazole 5 mg (used for manic-depressive illness) chlorthalidone 25 mg (for blood pressure)	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27280	A. BUILDING: _____ B. WING _____	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTIVATE HOME SERVICES	14673 CIMARRON AVENUE WEST ROSEMOUNT, MN 55068

(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
01760	Continued From page 13 gabapentin 300 mg (used for pain) lispro insulin pen sliding scale (for diabetes) On December 18, 2023, at 11:45 a.m. unlicensed personnel (ULP)-C entered the resident's room with registered nurse (RN)-D and the surveyor, and was observed to administer morning medication to R2. ULP-C then administered morning lispro insulin to R2. ULP-D failed to prime the insulin pen per manufacturer's instructions. On December 19, 2023, at 10:50 a.m. RN-D stated the expectation was to prime the insulin pen first, and that was how the staff were trained. RN-D stated the ULP-C failed to complete that step. Humalog (Lispro) insulin KwikPen instructions for use dated March 2013, instructed to prime the pen before each injection to ensure the pen is ready to dose and removes air that may collect in the cartridge during normal use. The licensee's undated, Medication Administration policy referenced MN statute 144A that refers to Homecare services, indicated medications are to be administered as ordered by the physician. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27280	A. BUILDING: _____ B. WING _____	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTIVATE HOME SERVICES	14673 CIMARRON AVENUE WEST ROSEMOUNT, MN 55068

(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
01890	Continued From page 14 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 dated when opened for one of one resident (R2) with insulin. 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: R2's diagnoses included anxiety, hypertension, and diabetes. R2's medication administration record (MAR) dated December 2023, indicated R2 took insulin lispro (Humalog) 100 u/ml (units/milliliter) 6 units subcutaneously with breakfast and lunch, and Lantus 18 units subcutaneously at bedtime. On December 18, 2023, at 11:45 a.m. unlicensed personnel (ULP)-C entered the resident's room with registered nurse (RN)-D and the surveyor, and was observed to administer morning insulin by lispro insulin pen to R2. R2's Lantus insulin pen was labeled with a	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27280	A. BUILDING: _____ B. WING _____	12/19/2023

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01890	Continued From page 15 discard date; however, the Lispro insulin pen lacked an open or expiration date. On December 19, 2023, at 10:50 a.m. RN-D stated the lispro insulin pen was not labeled and stated the expectation was to label the pen when first opened. Humalog (Lispro) insulin KwikPen instructions for use dated March 2013, identified the pen must be used within 28 days, or be discarded. The licensee's undated, Medication Administration policy, referenced MN statute 144A that refers to homecare services, indicated prior to administration of any medication the nurse will verify medication has not expired. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

Minnesota Department of Health
Environmental Health, FPLS
P.O Box 64975
Saint Paul
651-201-4500

Type: Full
Date: *12/19/23*
Time: 08:17:46
Report: 1018231231

Food and Beverage Establishment Inspection Report

Location:
Cimarron
14673 Cimarron Avenue West
Rosemount, MN55068
Dakota County, 19

Establishment Info:
ID #: 0037951
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9528480935
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.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Hot Water: = at 160 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding/ LETTUCE
Temperature: 41 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Process/Item: Cold Holding/ CHEESE
Temperature: 41 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

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

ESTABLISHMENT IS A RESIDENTIAL HOME WITH RESIDENTIAL EQUIPMENT.

DISHWASHER HAS SANITIZE FUNCTION AND TEMPERATURE STICKER CONFIRMED APPROPRIATE TEMPERATURE WAS REACHED INSIDE THE MACHINE.

FLOORS, WALLS, CEILINGS AND EQUIPMENT ARE ALL RESIDENTIAL AND WILL BE MONITORED THROUGH THE YEARS.

DISCUSSED PEST CONTROL.

ESTABLISHMENT HAS 2 BASIN HAND SINK WITH ONE SIDE DESIGNATED FOR HAND WASHING ONLY.

Food and Beverage Establishment Inspection Report

DISCUSSED EMPLOYEE ILLNESS AND VIEWED ILLNESS LOG.

NO ORDERS ISSUED.

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 1018231231 of 12/19/23.

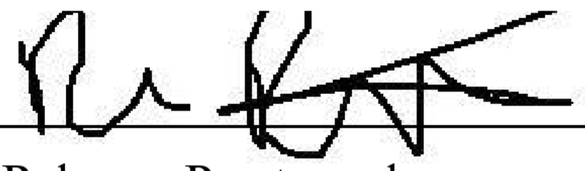
Certified Food Protection Manager: TENNA CHRISTIANSEN

Certification Number: FM107614 Expires: 08/27/24

Inspection report reviewed with person in charge and emailed.

Signed: _____

TENNA CHRISTIANSEN
MANAGER

Signed: 

Rebecca Prestwood
Sanitarian 3
6512013777
rebecca.prestwood@state.mn.us