Electronically Delivered

May 10, 2023

Licensee
Berkely Heights Homes LLC
6308 65th Avenue North
Brooklyn Center, MN 55429

RE: Project Number(s) SL38703015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial survey on April 12, 2023, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

The Department of Health 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 Department of Health documents state correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care 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 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 and enforcement actions 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
Per 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 residents/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

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

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

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

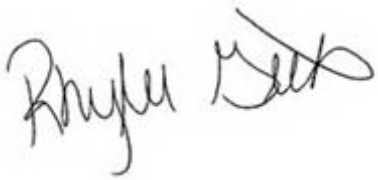
Please address your cover letter for reconsideration requests to:

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

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

If you have any questions, please contact me.

Sincerely,



Rhylee Gilb, Supervisor
State Rapid Response Team
Email: rhylee.gilb@state.mn.us
Telephone: 218-232-8285 Fax: 651-215-6894

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38703	A. BUILDING: _____ B. WING _____	04/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKELY HEIGHTS HOMES LLC	6308 65TH 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(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#38703015 On April 10, 2023, through April 12, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were three (3) residents receiving services under the Assisted Living/Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to comply with Minnesota Food Code, Chapter 4626. This had the potential to affect all three residents residing at the facility. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a 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: Please refer to the additional documentation included in the Food and Beverage Establishment Inspection Reports dated April 10, 2023, TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 480		
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	0 800		

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0 800	Continued From page 2 health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, 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 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). Findings include: On a facility tour on April 12, 2023, at approximately 10:00 a.m. with the licensed assisted living director (LALD)-C it was observed that there was water damage at the shower head in the basement bathroom. The paint was peeling above the tile finish and the drywall was cracked and damaged where the tile finish ended. The drywall in shower stalls should be in good condition with a water-resistant finish to inhibit the growth of mold and mildew. In both basement bedrooms, it was observed that	0 800		

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0 800	Continued From page 3 the window screens were not secured in the window frames and would allow pests and insects to enter the facility if the windows were opened. In the main level bathroom, it was observed that the paint on the drywall was cracking throughout the space and in some areas had started to flake off the wall. In occupied main level bedroom #1, the egress window had a damaged frame with sharp, broken plastic edges where the bottom frame had been ripped off the window. The plastic frame on the right edge of the window was hanging off the building by one secure point at the top. The wood in the window casing was stained black and had significant damage from weathering. There were dead bugs and spider webs were present in the window tracks and in between the windowpanes. In occupied main level bedroom #2, the egress window had spider webs present in between the windowpanes. The wood in the window casing was stained black and had significant damage from weathering. The operable windowpane was tightly fit into the frame and did not open easily. Egress windows in resident bedrooms must be provided and properly maintained in buildings not equipped with an automatic sprinkler system. In unoccupied main level bedroom #3, the egress window had wood in the window casing that was stained black and had significant damage from weathering. Parts of the wood in the frame system were crumbling to dust. The operable windowpane was tightly fit into the frame and did not open easily. Egress windows in resident	0 800		

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0 800	Continued From page 4 bedrooms must be provided and properly maintained in buildings not equipped with an automatic sprinkler system. In main level bedroom #3 it was observed that the floor had not been cleaned in a significant length of time and was covered in paint stains, what appeared to be spilled wax, miscellaneous debris, and a layer of dust that showed the surveyor's path of travel. The popcorn ceiling was filled with cobwebs throughout the space and the ceiling fan had a layer of dust one-quarter inch thick. The window blinds were broken and did not function properly. In the garage, there was a wheelchair ramp made of wood and plywood. The ramp did not appear to be structurally sound. There were no guardrails on the ramp and no proper landing space at the top and bottom. LALD-C stated the ramp was not currently being used by the facility residents. It was observed that the exterior deck had loose guardrails that wiggled significantly if any weight was put on them. The ramp leading up to the deck had an approximately three-foot section missing in the guardrail that could be a tripping or fall hazard for residents that used the ramp. Miscellaneous wood pieces with protruding nails were laying on the ground along the length of the deck. The privacy fence that enclosed the facility's backyard and separated the property from the neighboring property had an approximately six-foot-long portion that was damaged and collapsed. Miscellaneous wood pieces with protruding nails were laying on the ground along the length of the fence.	0 800		

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0 800	Continued From page 5 LALD-C visually verified these deficient findings at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (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	0 810		

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0 810	Continued From page 6 activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on a record review and interview, the licensee failed to develop a fire safety and evacuation plan with the required elements and failed to provide required employee and resident training on fire safety and evacuation. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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). Findings include: A record review and interview were conducted on April 12, 2023, at approximately 12:00 p.m. with the licensed assisted living director (LALD)-C on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not have employee actions to be taken in the event of a fire or similar emergency. The facility plan indicated to use RACE acronym but was very vague and did not provide complete actions for employees to take in the event of a fire or similar emergency. During	0 810		

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0 810	Continued From page 7 interview, LALD-C verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan. During interview, LALD-C verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of the available documentation indicated that the fire safety and evacuation plan did not include 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. The facility plan did include some provisions for the relocation of residents but did not specify how to move or evacuate residents or identify the unique and unusual needs of the residents. During interview, LALD-C verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of available documentation indicated that the licensee did not provide employee training on the fire safety and evacuation plan twice per year after the training at initial hire. During interview, LALD-C stated the licensee did not have any documented training for employees. Record review of the available documentation indicated that the licensee did not provide annual training to residents who can assist in their own evacuation on the proper actions to take in the event of a fire including movement, evacuation, or	0 810		

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0 810	Continued From page 8 relocation as required by statute. During interview, LALD-C stated that the facility did not have documentation on offering resident training on the fire safety and evacuation plan. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01650 SS=E	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters.	01650		

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01650	Continued From page 9 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included the required content for two of two residents (R1, R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1's diagnoses included diabetes, and renal failure. R1's service plan dated December 15, 2022, lacked: -the action to be taken if the scheduled service cannot be provided; and -the services of medication management and medication set-up were not listed. R2's diagnoses included depression, and obsessive-compulsive disorder. R2's service plan dated September 8, 2022, lacked: - the fees for services; -the services of medication management set-up; - the action to be taken if the scheduled service cannot be provided; and -the circumstances in which emergency medical	01650		

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01650	Continued From page 10 services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. On April 11, 2023, at 11:15 a.m., registered nurse (RN)-A who is also the director of nurses, confirmed R1 and R2's service plan do not contain the required content. The licensee's Service Plan policy effective August 1, 2021, noted the service plan must include: the fees for services and the frequency of each service, according to the resident's current review or assessment and resident preferences and the schedule and methods of monitoring reviews or assessments of the resident TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01650		
01700 SS=F	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues.	01700		

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01700	Continued From page 11 (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. 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 a face-to-face medication management assessment to include all required content for one of one resident (R1) with records reviewed. This deficient practice affected all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on April 10, 2023, 9:40 a.m., registered nurse (RN)-A, who was also the director of nursing (DON) and clinical supervisor, RN-B, and the licensed assisted living director (LALD)-C confirmed the licensee provided medication management services to the	01700		

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BERKELY HEIGHTS HOMES LLC	6308 65TH 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
01700	Continued From page 12 three residents at the facility. R1's diagnoses included, but were not limited to, diabetes, chronic renal disease. R1's service plan lacked any mention of medication management set-up service. R1's prescriber's orders dated December 15, 2022, included long acting insulin, short acting insulin, melatonin, carvedilol (heart medication), hydralazine (anti-hystamine), prednisone eye drops, tobramycin eye drops, losartan (heart medication), veltassa (for high potassium), atrovastatin (cholesterol medication), sevelamer carbonate (for kidneys), amlodipine besylate (heart medication), aspirin, acetaminophen (pain medication) and ondanstetron (anti-nausea). R1's record lacked evidence the RN conducted a face-to-face review of all medications the resident was known to be taking to include indications for use, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. In addition, the resident's records failed to identify interventions needed in the management of medications to prevent diversion of medications by the resident or others who may have access to the medications. On April 10, 2023, at 1:30 p.m., RN-B confirmed the above information was not located on the form and the same process is used for all of the residents in the establishment. The licensee's Assessment of Medications dated August 1, 2021, noted an assessment of the resident's need for medication management services would be completed face-to-face and would include: identification and review of all medications the resident was known to be taking;	01700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38703	A. BUILDING: _____ B. WING _____	04/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKELY HEIGHTS HOMES LLC	6308 65TH 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
01700	Continued From page 13 indications for medications; side effects; contraindications; allergic or adverse reactions and actions to address these issues and; interventions needed to prevent diversion of the medications by the resident or by others who may have access to the medications. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure documentation of medication setup included all the required content for one of one resident (R1) with records reviewed. This deficient practice affected all residents. 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:	01770		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38703	A. BUILDING: _____ B. WING _____	04/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKELY HEIGHTS HOMES LLC	6308 65TH 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
01770	Continued From page 14 During the entrance conference on April 10, 2023, at 9:40 a.m., registered nurse (RN)-A who also had the title of director of nurses (DON) and clinical supervisor, confirmed the licensee provided medication management services which included medication setup by the RN for all three residents. R1's record lacked documentation by the licensed nurse at the time of medication setup to include documentation of the dates of medication setup, and the name of the person completing medication setup. R1's diagnoses included diabetes, chronic kidney disease. R1's service plan lacked medication management service set-up. R1's Medication/Management Plan dated August 17, 2022, indicated the resident received medication management services to include medication setup. R1's prescriber's orders dated December 15, 2022, included long acting insulin, short acting insulin, melatonin, carvedilol (heart medication), hydralazine (anti-hystamine), prednisone eye drops, tobramycin eye drops, losartan (heart medication), veltassa (for high potassium), atrovastatin (cholesterol medication), sevelamer carbonate (for kidneys), amlodipine besylate (heart medication), aspirin, acetaminophen (pain medication) and ondanstetron (anti-nausea). R1's record lacked documentation for medication setup at the time of setup to include the dates of medication setup, the date of the set-up, and the name of the person completing medication setup as required.	01770		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38703	A. BUILDING: _____ B. WING _____	04/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKELY HEIGHTS HOMES LLC	6308 65TH 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
01770	Continued From page 15 On April 10, 2023, at 2:00 p.m., RN-A verified R1 received weekly medication setup services by the RN. RN-A verified R1's and the other residents who all receive their medications set-up, the medication setup was not documented to include the required content noted above. A policy was requested and was not received. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		

Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul
6512014500

Type: Full
Date: *04/10/23*
Time: 12:00:09
Report: 1029231072

Food and Beverage Establishment Inspection Report

Location:
BERKELY HEIGHTS HOMES LLC
6308 65th Avenue North
Brooklyn Park, MN55428
Hennepin County, 27

Establishment Info:
ID #: 0037859
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7633210351
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.

4-300 Equipment Numbers and Capacities

4-302.13B ***** Priority 2 *****

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

No temperature stickers or min/max thermometer at establishment to verify temperatures reached in the dishwasher. Instructed Michael to obtain temperature stickers or thermometer to verify maximum temperature.

Comply By: 04/14/23

Food and Equipment Temperatures

Process/Item: milk
Temperature: 36 Degrees Fahrenheit - Location: refrigerator
Violation Issued: No

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

Conducted inspection of food services area as part of a Health Regulation Division ("HRD") survey. Inspection conducted in the presence of Michael Nornie, CFPM/Person in Charge. Topics discussed with Michael included highly susceptible populations, employee illness reporting and exclusion procedures, vomit/fecal matter cleanup, sanitizing, common contagious foodborne illness pathogens (e.g., salmonella, shigella, shiga toxin-producing E. coli, hepatitis A virus, and norovirus), hygienic practices (e.g., handwashing), and general food safety practices (e.g., holding temperatures at or below 41°F and 135°F or above for TCS foods).

The kitchen was residential nature and had vinyl flooring, smooth painted walls and ceiling, laminate countertops and backsplash, and wood/composite MDF style wood cabinetry and drawers. Cabinetry and

drawers were highly worn with exposed MDF absorbent surfaces. There was also an accumulation of food debris, and dust on the cabinet surfaces and canned goods. Informed Michael that the surfaces should not be absorbent and that he kitchen area needed to be cleaned at a frequency to preclude the accumulation of food debris, and dust. Kitchen was in poor to fair condition.

The inspection findings were discussed with Lead HRD Surveyor, Carol Moroney, RN/Special Investigator/Nurse Evaluator, following the survey.

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 1029231072 of 04/10/23.

Certified Food Protection Manager: Michael Gbutu Nornie

Certification Number: FM111585 Expires: 03/22/25

Signed: _____
Michael Nornie
Person in Charge

Signed: _____
Trevor McCliment
Public Health Sanitarian
Metro District Office
651-201-3957
trevor.mccliment@state.mn.us

Report #: 1029231072

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul

No. of RF/PHI Categories Out	0	Date	04/10/23
No. of Repeat RF/PHI Categories Out	0	Time In	12:00:09
Legal Authority MN Rules Chapter 4626		Time Out	

	Address	City/State	Zip Code	Telephone
BERKELY HEIGHTS HOMES LLC	6308 65th Avenue North	Brooklyn Park, MN	55428	7633210351

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0037859		Full		

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	X	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) MN Rick Dow **Date:** 04/10/23

Inspector (Signature) Samuel McClintock