DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

November 15, 2022

Administrator
Triple Angels Healthcare
7150 West Point Douglas Road South
Cottage Grove, MN 55016

RE: Project Number(s) SL34363015

Dear Administrator:

On November 9, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the August 31, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,

Jess Gallmeier, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-247-0268 Fax: 651-215-9697

PMB

Electronically Delivered

October 3, 2022

Administrator
Triple Angels Healthcare
7150 West Point Douglas Road South
Cottage Grove, MN 55016

RE: Project Number(s) SL34363015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on August 31, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2,

9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

St - 0 - 0470 - 144g.41 Subdivision 1 - Minimum Requirements = $3,000
St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program = $500
St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required = $3,000

The total amount you are assessed is $6,500. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

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

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

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:	Free from Maltreatment reconsideration requests should be addressed to:

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

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

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. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

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.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Jess Gallmeier, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-247-0268 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34363	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIPLE ANGELS HEALTHCARE	7150 WEST POINT DOUGLAS ROAD S COTTAGE GROVE, MN 55016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL34363015 On, August 30 through August 31, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 9 residents, all receiving services under the provider's Assisted Living with dementia care license. On August 31, 2022, the immediacy of correction orders 0470 and 1290 have been removed, however non-compliance remains at a scope and level of I.	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 Home Care/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 144A.474 subd. 11 (b) (1) (2) -or- 144G.31 subd. 1, 2 and 3	

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0 450	Continued From page 1	0 450		
0 450 SS=F	144G.41 Subdivision 1 Minimum requirements All assisted living facilities shall: (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide the current assisted living bill of rights to one of one resident (R1) with record reviewed. Additionally, the licensee failed to provide services in a person-centered manner. This had the potential to affect all residents receiving services. 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: BILL OF RIGHTS	0 450		

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0 450	Continued From page 2 R1 admitted for services on June 14, 2019. R1's record lacked evidence R1 had received the assisted living bill of rights. PERSON CENTERED CARE On August 30, 2022, at approximately 11:30 a.m., two unlicensed personnel (ULP) provided nutritional assistance to residents. Residents were seated in their respective wheelchairs while ULPs stood over multiple residents while providing nutritional assistance. On August 31, 2022, at approximately 12:00 p.m., registered nurse (RN)-A acknowledged there were no documentation that R1 received the assisted living bill of rights. RN-A also acknowledged all ULPs should be at eye level of all residents during nutritional assistance. The licensee's Notifications policy dated August 1, 2021, indicated the licensee would provide the resident or the resident's representative with a written notice of rights upon admission and documented it in resident's record. The licensee's Policies Specific to Assisted Living with Dementia Care dated August 1, 2021, indicated all staff will be trained on person-centered planning and service delivery. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 450		
0 470 SS=I	144G.41 Subdivision 1 Minimum requirements	0 470		

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0 470	Continued From page 3 (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide adequate staffing to meet the needs of one of one resident (R3), who required two person transfers with a mechanical lift, with record reviewed. This has the potential to affect all residents. This practice resulted in a level three violation (a violation that harmed a resident's health or safety,	0 470		

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0 470	Continued From page 4 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: R3 admitted on May 2, 2022. R3's Exhibit 2: Service Plan indicated under interventions for mobility and safety, R3 required two staff for all transfers. R3's Resident Evaluation dated May 2, 2022, indicated R3 required "total assist with EZ-stand" and "two staff assist for dressing." The licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) dated May 4, 2022, indicated on page two, the licensee would staff two unlicensed personnel (ULP) and on page ten, the licensee offered transfers with assist of two staff. The licensee's August 2022 Staff Schedule indicated one ULP worked the overnight shift with nightly shifts that varied from 10:00 p.m. until 5:00 a.m. or 11:00 p.m. until 5:00 a.m. On August 30, 2022, during entrance conference at approximately 9:00 a.m., registered nurse (RN)-A, stated the licensee staffed one ULP for all night shifts. On August 30, 2022, at approximately 2:00 p.m., RN-A stated R3 required two ULPs for all transfers.	0 470		

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0 470	Continued From page 5 The licensee's Staffing policy dated August 1, 2021, indicated the licensee would staff based on "scheduled and reasonably foreseeable unscheduled needs of the residents based on the assessment." No further information provided. TIME PERIOD FOR CORRECTION: Immediate Immediacy is removed as confirmed by evaluation supervisor document review on August 31, 2022, however noncompliance remains at a scope and severity of I. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and	0 480		

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0 480	Continued From page 6 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 9 residents residing at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the additional documentation included in the Food and Beverage Establishment Inspection Reports dated August 30, 2022. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 480		
0 485 SS=C	144G.41 Subd 1. (13) (i) (A) and (C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply:	0 485		

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0 485	Continued From page 7 (A) menus must be prepared at least one week in advance, and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; (C) the facility cannot require a resident to include and pay for meals in their contract; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a menu was nutritious and failed to provide meal substitutions that are equally nutritious according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines. This had the potential to affect all nine (9) residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 30, 2022, at approximately 9:00 a.m., registered nurse (RN)-A stated meals were prepared by the licensee. On August 30, 2022, at approximately 11:30 a.m., the surveyor observed the lunch provided did not contain fruit of any kind or the required amount of	0 485		

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0 485	Continued From page 8 protein. The licensee's weekly menu, undated, did not contain fresh fruits and vegetables for fifteen of twenty-one meals provided. The menu also did not contain alternative meals of similar nutritional value. On August 30, 2022, at approximately 12:00 p.m., RN-A acknowledged the menu did not meet the USDA guidelines nor did it provide alternate meals of similar nutritional value. The licensee's Food Service policy dated August 1, 2021, indicated at least three nutritious meals are served seven days per week with snacks available based on USDA guidelines. The policy indicated meal substitution will be of a similar nutritional value. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of	0 510		

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0 510	Continued From page 9 compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the licensee failed to establish and maintain an infection control program that complies with accepted health care, medical and nursing standards for infection control. The deficient practice has the potential to affect residents, employee, 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 all staff, residents and visitors.) The findings include: On August 30 through August 31, 2022, during the course of the survey, the surveyors observed multiple employees not wearing face mask in the proper manner while providing services to residents, including having face masks below the nose, below the chin, and one employee not wearing a mask. Additionally, the surveyors did not observe employees wear eye protection at any point during the survey, including while providing medications in a resident's room. The Minnesota Department of Health (MDH) guidance titled, "COVID-19 PPE and Source Control Grids - for congregate care settings, by community transmission level", dated April 7, 2022, indicated during "substantial" or "high" levels of community transmission (based on the	0 510		

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0 510	Continued From page 10 Centers for Disease Control and Prevention (CDC) online data tracking system), caregivers must wear a face mask (source control) and eye protection while working with residents without suspected or confirmed SARS-CoV-2 infection. The CDC COVID Data Tracker on August 31, 2022, indicated Washington County, Minnesota (the county of the assisted living facility) was at a "high" level of community transmission, which indicated the use of a face mask and eye protection while working with residents. On August 31, 2022, at approximately 12:00 p.m., registered nurse (RN)-A and administrator (A)-C acknowledged staff were not wearing masks in the proper manner. RN-A stated the licensee followed the CDC and MDH guidelines and additional training would be provided to staff to ensure compliance. The licensee's Infection Control policy dated August 1, 2021, indicated the licensee would follow guidance from the CDC and wear personal protective equipment as indicated. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
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 e-mail contact information for the individuals who are responsible for handling resident grievances.	0 550		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIPLE ANGELS HEALTHCARE	7150 WEST POINT DOUGLAS ROAD S COTTAGE GROVE, MN 55016

(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
0 550	Continued From page 11 The notice must also have the contact information for the state and applicable regional 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. 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 and contact information for the Office of Ombudsman for Long-Term Care and Mental Health and Developmental Disabilities, as well as information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). This had the potential to affect all 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, 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 facility tour on August 30, 2022, at approximately 9:30 a.m., the common areas shared by residents, staff, and visitors, lacked the required posting of the grievance procedure, contact information for the Ombudsman, and information related to reporting suspected maltreatment to MAARC.	0 550		

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0 550	Continued From page 12 On August 31, 2022, at approximately 12:00 p.m., registered nurse (RN)-A acknowledged the required content was not posted in the common areas. RN-A stated they were unaware of the requirement. The licensee's Grievance policy dated August 1, 2021, indicated a copy of the grievance procedure would be conspicuously posted in the residence with the required information. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must	0 680		

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0 680	Continued From page 13 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 observation, interview and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all required content and posted the emergency disaster plan prominently. 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, 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: On August 30, at approximately 9:30 a.m., during facility tour, the surveyor did not observe the licensee's EPP posted prominently in the common area. The surveyor observed the EPP in a locked office. The licensee's EPP lacked all required content including: -Under establishment of emergency program, not all forms were completed, some were left blank.	0 680		

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0 680	Continued From page 14 On August 31, 2022, at approximately 12:00 p.m., registered nurse (RN)-A acknowledged EPP had missing content and the EPP needed to be posted prominently. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated the emergency disaster plan would be prominently posted. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code,	0 780		

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0 780	Continued From page 15 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 smoke alarms in all the sleeping rooms through-out and or smoke alarms are interconnected so that actuation of one alarm causes all alarms in the dwelling to actuate as required to the fire alarm system. 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, but was not likely to cause serious injury, impairment, or death), and 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 residents). The findings include: On August 30, 2022, between 0900 and 1030am, survey staff toured the facility with LAID-A-C. During the facility tour, survey staff observed there are no smoke detectors in all sleeping rooms and the exoisting fire alarm system has not be inspected or testing annually. LAID-A-C verbally confirmed survey staff observations during the facility tour. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		

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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 interviewed, the licensee failed to maintain the facility physical environment in a continuous state of good repair and operation regarding 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 residents). The findings include: On August 31,2022, from approximately 0900 to 1030, survey staff toured the facility with LALD-A-C. During the facility tour, survey staff observed that the outdoor activities area is being used as a smoking area and does not have a approved smoking container and no smoking signage posted.. LALD-A-C verbally confirmed survey staff	0 800		

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0 800	Continued From page 17 observations during the facility tour. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 970 SS=F	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for the health, safety, or personal property of a resident. This had the potential to affect 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:	0 970		

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0 970	Continued From page 18 On August 30, 2022, at approximately 9:00 a.m., during the entrance conference, registered nurse (RN)-A provided the licensee's Assisted Living Contract and indicated the contract is signed by all residents who received services under the licensee's assisted living facility with dementia care license. The licensee's undated Assisted Living Contract which contained language under Miscellaneous Provisions 1. Insurance Liability and Release indicated the resident agreed that the licensee "will not be liable to the resident for any personal injury or property damage." The licensee's blank assisted living contract also indicated all residents would have a completed assisted living contract prior to admission. On August 31, 2022, at approximately 12:00 p.m., RN-A acknowledged the licensee's assisted living contract contained language which waived the licensee's liability for the residents' health and safety and personal property. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information.	01290		

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01290	Continued From page 19 (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, licensee failed to maintain a current background study in employee records for one of one unlicensed personnel (ULP-(B)), with record reviewed. 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: ULP-B was hired on January 3, 2022. ULP-B's record included a background study dated October 20, 2020. ULP-B's record included a termination letter from ULP-B to the licensee dated November 17, 2020. ULP-B's record included an Employment Application dated January 3, 2022.	01290		

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01290	Continued From page 20 On August 30, 2022, at approximately 11:30 a.m., ULP-B provided nutrition and activities of daily living to multiple residents during lunch. On August 30, 2022, at approximately 2:00 p.m., registered nurse (RN)-A stated ULP-B separated employment on November 17, 2020, and was rehired on January 3, 2022. RN-A provided background study from previous employment with licensee but did not obtain a new background study upon rehire. The licensee's Personnel Records policy dated August 1, 2021, indicated employees would have current background studies included in their record. No further information provided. TIME PERIOD FOR CORRECTION: Immediate Immediacy is removed as confirmed by evaluation supervisor document review on August 31, 2022, however noncompliance remains at a scope and severity of I. TIME PERIOD FOR CORRECTION: Seven (7) days	01290		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility;	01370		

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01370	Continued From page 21 (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure training and competency was completed for one of one employee (unlicensed personnel (ULP)-B) to include all required content with training record	01370		

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01370	Continued From page 22 reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-B was hired on January 3, 2022. On August 31, 2022, throughout the day, ULP-B provided activities of daily living services to multiple residents. ULP-B's employee file lacked all documentation of training and thirty-day competency evaluation by a registered nurse. On August 31, 2022, at approximately 12:00 p.m., registered nurse (RN)-A acknowledged ULP-B's personnel file did not contain documentation ULP-B had completed training in all required areas. RN-A indicated ULP-B will complete the required training to meet the requirements. The licensee's Staff Competency policy dated August 1, 2021, indicated training and competency evaluations for all unlicensed personnel would be completed and kept in employee records. No further information was provided. TIME PERIOD FOR CORRECTION:	01370		

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01370	Continued From page 23 Twenty-One (21) days	01370		
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care to residents for one of one (unlicensed personnel (ULP)-B) with employee record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or	01380		

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01380	Continued From page 24 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-B was hired on January 3, 2022. On August 31, 2022, throughout the day, ULP-B provided activities of daily living services to multiple residents. ULP-B's employee record lacked all documentation of training and thirty day competency evaluations by a registered nurse. On August 31, 2022, at approximately 12:00 p.m., registered nurse (RN)-A acknowledged ULP-B's personnel file did not contain documentation ULP-B had completed training in all required areas. RN-A indicated ULP-B will complete the required training to meet the requirements. The licensee's Staff Competency policy dated August 1, 2021, indicated training and competency evaluations for all unlicensed personnel would be completed and kept in employee records. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01380		
01540 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics	01540		

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TRIPLE ANGELS HEALTHCARE	7150 WEST POINT DOUGLAS ROAD S COTTAGE GROVE, MN 55016

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01540	Continued From page 25 specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the required eight hours of dementia care training was completed within 80 hours of the employment start date for one of one employee (unlicensed personnel (ULP)-B) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-B was hired by the licensee on January 3, 2022, to provide assisted living services to the licensee's residents.	01540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34363	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIPLE ANGELS HEALTHCARE	7150 WEST POINT DOUGLAS ROAD S COTTAGE GROVE, MN 55016

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01540	Continued From page 26 On August 31, 2022, ULP-B provided activities of daily living to multiple residents throughout the day. ULP-B's employee record and training transcripts lacked evidence ULP-B completed the required eight (8) hours of dementia care training. On August 31, 2022, at approximately 12:00 p.m., registered nurse (RN)-A provided documentation ULP-B had two (2) hours of dementia care training on April 22, 2022, and acknowledged ULP-B's employee record lacked evidence of eight (8) hours of the required dementia care training. RN-A indicated ULP-B has been assigned courses that will include the remaining dementia training required. The licensee's Dementia Education policy dated August 1, 2021, indicated direct care employees must complete at least eight (8) hours of initial education within 160 working hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01540		
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility	01940		

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01940	Continued From page 27 must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure residents' service plans included all required content for one of one resident (R1) with record 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 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).	01940		

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01940	Continued From page 28 The findings include: R1's Service Plan: Part 2 dated June 18, 2021, identified by registered nurse (RN)-A as R1's current service plan, lacked identification of R1's blood glucose treatment. R1's Medication Administration Record (MAR) dated August 2022, indicated on page one of Routine Medications, R1 received Accu Check (blood glucose checks) three times daily. On August 31, 2022, at approximately 12:00 p.m., RN-A acknowledged R1 received blood glucose check treatment three times daily but the service was not listed on R1's Service Plan. RN-A stated all services residents received should be listed on each residents' respected service plans. The licensee's Service Plan policy dated August 1, 2021, indicated all services provided to residents would be included in each residents' service plans. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01940		
02110 SS=C	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's	02110		

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02110	Continued From page 29 values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living facility with dementia care provided the required policies and procedures to one of one resident (R1) with record reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than	02110		

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02110	Continued From page 30 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 potential to affect a large portion or all of the residents). The findings include: R1 was admitted on June 14, 2021. R1's record lacked documentation for receipt of required policies and procedures to be provided as of August 1, 2021. On August 31, 2022, at approximately 12:00 p.m., registered nurse (RN)-A stated the policies were created, but not provided to R1. RN-A indicated the licensee was not aware the policies were required to be given to the resident or the resident's representative at time of move-in. The licensee's Policies Specific To Assisted Living with Dementia Care dated August 1, 2021, included all required policies and procedures to be provided to residents as of August 1, 2021. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following:	02170		

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02170	Continued From page 31 (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individualized activity plan contained all required content for one of one resident (R1) with record reviewed. This practice resulted in a level two violation (a	02170		

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02170	Continued From page 32	02170		

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:

R1 admitted on June 14, 2019.

R1's record lacked an evaluation which addressed the following: past and current interests; current abilities and skills; emotional and social needs and patterns; physical abilities and limitations; adaptations necessary for the resident to participate; and identification of activities for behavioral interventions.

On August 31, 2022, at approximately 12:00 p.m., registered nurse (RN)-A acknowledged an activities and preference evaluation was not completed for R1. RN-A indicated the licensee was not aware of the required evaluation.

The licensee's Policies Specific to Assisted Living with Dementia Care dated August 1, 2021, indicated all appropriate areas and topics the required evaluation would include.

No further information provided.

TIME PERIOD FOR CORRECTION: Seven (7) days

Minnesota Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *08/30/22*
Time: 13:29:23
Report: 1021221243

Food and Beverage Establishment Inspection Report

Location:
Triple Angels Healthcare
7150 West Point Douglas Road S
Cottage Grove, MN55016
Washington County, 82

Establishment Info:
ID #: 0038521
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 6514589401
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

4-302.12B ** Priority 2 **

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

NO THIN PROBE FOOD THERMOMETER ON-SITE. ESTABLISHMENT HAS A DIAL FOOD THERMOMETER WITH A THICK PROBE FOR ROASTS AND OTHER MEATS THAT GO IN THE OVEN. PROVIDE AS DESCRIBED IN RULE ABOVE.

Comply By: 10/03/22

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.

ESTABLISHMENT DOES NOT HAVE A MEASURING DEVICE ON-SITE THAT INDICATES THE FINAL UTENSIL SURFACE TEMPERATURE IN HIGH TEMPERATURE DISH MACHINE. PROVIDE. THERMOLABELS WERE LEFT ON-SITE. SEE COMMENTS.

Comply By: 09/02/22

4-300 Equipment Numbers and Capacities

4-302.14 ** Priority 2 **

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

NO TEST KIT ON-SITE TO MEASURE THE CONCENTRATION OF CHLORINE. PROVIDE AS DESCRIBED IN RULE ABOVE.

Comply By: 09/02/22

6-300 Physical Facility Numbers and Capacities

6-301.12 ** Priority 2 **

MN Rule 4626.1445 Provide and maintain a supply of individual disposable towels, a continuous towel system, a heated-air hand drying device, or an approved ambient air temperature hand drying device at each handwashing sink or group of adjacent handwashing sinks.

NO PAPER TOWELS AT THE HANDWASHING SINK. STAFF PROVIDED PAPER TOWELS DURING INSPECTION. CORRECTED ON-SITE. MAINTAIN A SUPPLY OF PAPER TOWELS AT THE HANDWASHING SINK DURING ALL HOURS OF OPERATION.

Comply By: 08/30/22

7-100 Toxic Labeling

7-102.11 ** Priority 2 **

MN Rule 4626.1595 Clearly label all working containers used for storing poisonous or toxic materials from bulk supplies such as sanitizers and cleaners, with the common name of the product.

TWO CLEAR SPRAY BOTTLES WITH UNKNOWN CHEMICALS FOUND IN THE KITCHEN WITHOUT A LABEL. DIRECTOR LABELED SPRAY BOTTLES WITH THE COMMON NAME OF THE PRODUCT DURING INSPECTION. CORRECTED ON-SITE.

Comply By: 08/30/22

Surface and Equipment Sanitizers

Chlorine: = 50PPM at Degrees Fahrenheit
Location: SANI BUCKET, KITCHEN
Violation Issued: No

Final Utensil Surface Temp: = at 165 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: ALMOND MILK - NORLAKE 2 DOOR COOLER
Violation Issued: No

Process/Item: Re-Heating
Temperature: 199 Degrees Fahrenheit - Location: TUNA WITH VEGGIES - STOVE
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	5	0

ALL FINDINGS ON THIS REPORT WERE DISCUSSED WITH FACILITY DIRECTOR, ADENIKE OGUNRINDE AND HEALTH REGULATION DIVISION NURSE EVALUATORS, ANNA BOHNEN AND BRANDON MUELLER.

FACILITY CURRENTLY HAS 9 CLIENTS.

PER CONVERSATION WITH ADENIKE, FOOD IS MADE FOR SAME DAY SERVICE. NO LEFTOVERS ARE KEPT.

CONTINUATION OF MN Rule 4626.0710B :
THE THERMOLABELS WILL HELP THE ESTABLISHMENT VERIFY THAT THEIR DISH MACHINE IS PROVIDING A FINAL UTENSIL SURFACE TEMPERATURE OF 160F OR ABOVE.

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 1021221243 of 08/30/22.

Certified Food Protection Manager: ADENIKE S. OGUNRINDE

Certification Number: FM101428 Expires: 10/31/22

Inspection report reviewed with person in charge and emailed.

Signed: _____
ADENIKE OGUNRINDE
DIRECTOR

Signed: _____
Melissa Ramos
Environmental Health Specialist
Metro District Office
651-201-4495
Melissa.Ramos@state.mn.us