Electronically Delivered
February 13, 2023

Licensee
Cherrywood Of Andover
1889 139th Avenue Northwest
Andover, MN 55304

RE: Project Number(s) SL29743015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on January 6, 2023, 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.

LICENSING ORDERS
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 . . ."

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 evaluation of your facility**.

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 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 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 Schoenecker, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: Jess.Schoenecker@state.mn.us
Phone: 651-201-3789 Fax: 651-215-9697

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29743	A. BUILDING: _____ B. WING _____	01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRYWOOD OF ANDOVER	1889 139TH AVENUE NW ANDOVER, MN 55304

(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#29743015 On January 3, through January 6, 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 17 active residents receiving services under the Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated January 5, 2023, for the specific Minnesota Food Code deficiencies.	0 480		

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

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0 680	Continued From page 3 had the potential to affect all residents, employees, and visitors to the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On January 3, 2023, at approximately 11:00 a.m., during a tour of the facility, the surveyors did not observe an EPP posted prominently. On January 5, 2023, at 3:15 p.m., the surveyors requested to review the licensee's emergency disaster plan. Assisted living director (ALD)-D retrieved a 3-ringed binder from the ALD-D's office and identified the binder as licensee's EPP. The document titled 1.1 Organizational Review and Approval Log, was signed by the licensee's administrator on August 1, 2021. The EPP lacked the following required content: -2022 signed annual review acknowledgement; and -missing resident plan quarterly review. On January 3, 2023, at 11:10 a.m., ALD-D acknowledged the licensee's EPP was not posted prominently and lacked the required content. The licensee's 9.01 Emergency Preparedness Plan-Appendix Z Compliance policy dated August 1, 2021, indicated the licensee's EPP would include all required elements of appendix Z. Additionally, the plan would be in writing and	0 680		

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0 680	Continued From page 4 reviewed annually. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to maintain portable fire extinguishers in accordance with the State Fire Code as required by MN Statute 144G.45 Subd(a)(2). This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all	0 790		

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0 790	Continued From page 5 of the residents). The findings include: On January 3, 2023, from approximately 2:30 p.m. to 4:20 p.m., survey staff toured the facility with the maintenance staff (M)-E. During the tour, survey staff observed portable fire extinguishers located throughout the facility were all tagged showing the required annual service date of 4/2022, but all lacked the records to show the required monthly visual inspections to date. The M-E verified the findings. On January 3, 2023, at approximately 4:30 p.m., the assisted living director-D acknowledged the above findings at the exit interview. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of all residents	0 800		

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0 800	Continued From page 6 and staff. 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). On January 3, 2023, from approximately 2:30 p.m. to 4:20 p.m., survey staff toured the facility with the maintenance staff (M)-E. During the tour, survey staff observed and the M-E verified the following: 1. A large household bleach and laundry detergents were not secured from memory care residents in the laundry room as the door to the laundry room was unlocked, and in addition, another jug of bleach was observed next to the toilet of the central bathroom of building 1889. 2. In the open kitchens/dining common areas of buildings 1889 and 1899, commercial-type hot water dispensers (directly connected to the water system) were readily accessible to residents (all memory care) which posed scalding concerns. The dispenser located in building 1889 was verified at 179 degrees Fahrenheit (F) and the dispenser in building 1899 was at 186 degrees F. At the time of the tour of building 1889, approximately 3:00 p.m., no employee was present in the common/kitchen area. 3. In the open kitchens/dining common areas of buildings 1889 and 1899, the licensee failed to turn off the main switch provided to shut off the stovetops and oven appliances in accordance	0 800		

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0 800	Continued From page 7 with the licensee's policy in section 7 of the appendices (page 127) which states, "shut off switch available when not in use". The findings were evident as the M-E and survey staff observed power to both the stovetops and ovens located in areas accessible to all memory care residents and therefore, pose concerns of hot surfaces and burns from mis-use or accident use by residents. On January 3, 2023, at approximately 4:30 p.m., the assisted living director(ALD)-D acknowledged the above findings at the exit interview. The ALD-D stated most of their other communities have similar designs of open kitchens/common areas. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care.	01640		

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01640	Continued From page 8 (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the current service plan included a signature or other authentication by the resident and the licensee to document agreement on the services to be provided for. Additionally, the licensee failed to ensure a current written service plan was revised to reflect the current services provided for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 admitted to the licensee on February 9, 2016. R2's diagnoses included but were not limited to multiple sclerosis (MS) (loss of body control), weakness, adult failure to thrive, and edema (swelling).	01640		

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01640	Continued From page 9 On January 5, 2023, at 1:20 p.m., the surveyor interviewed R2, who was lying in bed. The surveyor observed an oxygen unit within the room and R2 indicated oxygen was applied every night at bedtime. R2's Service Plan dated November 6, 2021, did not indicate R2 was on hospice or received oxygen therapy. Additionally, there was no signature from R2, only the licensee's registered nurse's signature. R2's Medication Review Report signed by a physician on July 26, 2022, included orders for oxygen one liter per minute (LPM) per nasal cannula (tube that brings oxygen to nostrils) every night at bedtime. R2's medical record dated December 2022, indicated R2 had oxygen one LPM per nasal cannula every night at bedtime and removed every morning. On January 3, 2023, at 1:55 p.m., clinical nurse supervisor (CNS)-A indicated R2's service plan was not updated to reflect the current services received and that it was not signed. Additionally, CNS-A indicated he/she had updated about 60 percent (%) of all residents' service plans to meet the requirements and R2 was one that wasn't completed yet. The licensee's 6.08 Service Plan policy dated August 1, 2021, indicated the service plan and any revisions shall include a signature or other authentication by licensee and by the resident, or resident's representative, documenting agreement on the services to be provided. Additionally, service plans shall be revised based	01640		

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01640	Continued From page 10 on resident reassessments and monitoring. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01650 SS=D	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 11 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included the required content for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 admitted to the licensee on February 9, 2016. R2's diagnoses included but were not limited to multiple sclerosis (MS) (loss of body control), weakness, adult failure to thrive, and edema (swelling). R2's Service Plan dated November 6, 2021, indicated R2 needed assistance with medication administration, dressing, toileting, grooming, mobility, catheter care, laundry, and housekeeping. R2's current service plan lacked the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences. On January 3, 2022, at 2:09 p.m., clinical nurse supervisor (CNS)-A acknowledged the above information was not included on the service plan	01650		

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01650	Continued From page 12 for R2. Additionally, CNS-A indicated he/she had updated about 60 percent (%) of all residents' service plans to meet the requirements and R2 was one that wasn't completed yet. The licensee's 6.08 Service Plan policy dated August 1, 2021, indicated the licensee would include the frequency of each service to be provided based on the most recent assessment, and fees for services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to monitor for expired medications for two of two residents (R4, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29743	A. BUILDING: _____ B. WING _____	01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRYWOOD OF ANDOVER	1889 139TH AVENUE NW ANDOVER, MN 55304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01890	Continued From page 13	01890		

than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).

The findings include:

On January 3, 2023, at 10:15 a.m., during entrance conference, clinical nurse supervisor (CNS)-A indicated the licensee provided medication administration to all residents.

On January 5, 2022, at 9:00 a.m., the surveyors reviewed the controlled substances cabinet located in the assisted living director (ALD)-D's office with licensed practical nurse (LPN)-C. The surveyors noted expired medications for R4 and R5.

R4 had the following expired medications:
-morphine 2.5 milligrams (mg) (for pain), expired on July 15, 2021;
-lorazepam 0.5 mg (for anxiety), expired on April 2022; and
-lorazepam 0.5 mg, expired on December 2022.

R5 had the following expired medications:
-lorazepam 0.5 mg, expired November 8, 2022; and
-morphine 5 mg, expired November 7, 2022.

On January 5, 2022, at 11:06 a.m., CNS-A indicated R4's replacement medications were ordered on the pharmacy's "Refill Request Fax Form," on December 5, 2022, but pharmacy never delivered it. No staff followed up on the order request. For R5's replacement medications, CNS-A indicated staff ordered them verbally, yet medications were not delivered.

The licensee's 7.23 Medication Storage policy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29743	A. BUILDING: _____ B. WING _____	01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRYWOOD OF ANDOVER	1889 139TH AVENUE NW ANDOVER, MN 55304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01890	Continued From page 14 dated August 1, 2021, indicated the licensee would dispose of current unused controlled substances that were expired in accordance with accepted practices of the Minnesota Board of Pharmacy. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

Minnesota Department of Health

625 North Robert Street
Saint Paul, MN
651-201-5000

Type: Full
Date: *01/05/23*
Time: 16:00:00
Report: 8087231022

Food and Beverage Establishment Inspection Report

Location:
Cherrywood Of Andover
1889 139th Avenue Nw
Andover, MN55304
Anoka County, 02

Establishment Info:
ID #: 0038752
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3202577445
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

2-100 Supervision

2-102.12AMN

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

THERE IS NO FULL TIME STATE CERTIFIED FOOD PROTECTION MANAGER AT THE ESTABLISHMENT. HIRE A FULL TIME EMPLOYEE OR TRAIN AN EXISTING FULL TIME EMPLOYEE AND APPLY FOR THE STATE CERTIFIED FOOD PROTECTION MANAGER CERTIFICATE.

Comply By: 03/31/23

Food and Equipment Temperatures

Process/Item: Ambient Air
Temperature: 40 Degrees Fahrenheit - Location: KITCHEN #1 - MAYTAG FRIDGE
Violation Issued: No

Process/Item: Cold Holding: MILK
Temperature: 40 Degrees Fahrenheit - Location: KITCHEN #1 - MAYTAG FRIDGE
Violation Issued: No

Process/Item: Cold Holding: EGGS
Temperature: 40 Degrees Fahrenheit - Location: KITCHEN #1 - MAYTAG FRIDGE
Violation Issued: No

Process/Item: Cold Holding: CUT LFY GRN
Temperature: 40 Degrees Fahrenheit - Location: KITCHEN #1 - MAYTAG FRIDGE
Violation Issued: No

Process/Item: Ambient Air
Temperature: 9 Degrees Fahrenheit - Location: KITCHEN #1 - MAYTAG FREEZER
Violation Issued: No

Process/Item: Ambient Air
Temperature: 39 Degrees Fahrenheit - Location: KITCHEN #1 - SAMSUNG FRIDGE
Violation Issued: No

Process/Item: Cold Holding: YOGURT
Temperature: 37 Degrees Fahrenheit - Location: KITCHEN #1 - SAMSUNG FRIDGE
Violation Issued: No

Process/Item: Cold Holding: DELI MEAT
Temperature: 38 Degrees Fahrenheit - Location: KITCHEN #1 - SAMSUNG FRIDGE
Violation Issued: No

Process/Item: Cold Holding: CHEESE
Temperature: 39 Degrees Fahrenheit - Location: KITCHEN #1 - SAMSUNG FRIDGE
Violation Issued: No

Process/Item: Ambient Air
Temperature: 10 Degrees Fahrenheit - Location: KITCHEN #1 - SAMSUNG FREEZER
Violation Issued: No

Process/Item: Ambient Air
Temperature: 39 Degrees Fahrenheit - Location: KITCHEN #2 - FRIGIDARE FRIDGE
Violation Issued: No

Process/Item: Cold Holding: MILK
Temperature: 39 Degrees Fahrenheit - Location: KITCHEN #2 - FRIGIDARE FRIDGE
Violation Issued: No

Process/Item: Cold Holding: POTATO SALAD
Temperature: 39 Degrees Fahrenheit - Location: KITCHEN #2 - FRIGIDARE FRIDGE
Violation Issued: No

Process/Item: Cold Holding: CUT LFY GRN
Temperature: 40 Degrees Fahrenheit - Location: KITCHEN #2 - FRIGIDARE FRIDGE
Violation Issued: No

Process/Item: Ambient Air
Temperature: 18 Degrees Fahrenheit - Location: KITCHEN #2 - FRIGIDARE FREEZER
Violation Issued: No

Process/Item: Ambient Air
Temperature: 39 Degrees Fahrenheit - Location: KITCHEN #2 - SAMSUNG FRIDGE
Violation Issued: No

Process/Item: Cold Holding: COTTAGE CHZ
Temperature: 39 Degrees Fahrenheit - Location: KITCHEN #2 - SAMSUNG FRIDGE
Violation Issued: No

Process/Item: Cold Holding: DELI MEAT
Temperature: 39 Degrees Fahrenheit - Location: KITCHEN #2 - SAMSUNG FRIDGE
Violation Issued: No

Process/Item: Cold Holding: CHEESE
Temperature: 40 Degrees Fahrenheit - Location: KITCHEN #2 - SAMSUNG FRIDGE
Violation Issued: No

Process/Item: Cold Holding: MILK
Temperature: 39 Degrees Fahrenheit - Location: KITCHEN #2 - SAMSUNG FRIDGE
Violation Issued: No

Process/Item: Ambient Air
Temperature: 9 Degrees Fahrenheit - Location: KITCHEN #2 - SAMSUNG FREEZER
Violation Issued: No

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

THIS WAS AN UNANNOUNCED AND UNSCHEDULED FULL INSPECTION.

INSPECTION DONE WITH NURSE EVALUATOR ANNA BOHNEN.

TOPICS OF DISCUSSION WITH OPERATOR INCLUDED:

HAND WASHING
NOROVIRUS
BARE HAND CONTACT WITH READY TO EAT FOODS
EMPLOYEE ILLNESS
EMPLOYEE EXCLUSION
COOLING METHODS
REHEATING METHODS
SANITIZER CONCENTRATION
DATE MARKING
ALL ITEMS ON THIS REPORT
ALL ITEMS ON PREVIOUS REPORT

ALL FROZEN FOODS FOUND IN FROZEN CONDITION.

HOT WATER TEMPERATURES FOR THE COFFEE MACHINES MEASURED AT 179 AND 186 DEGREES FAHRENHEIT.

BOSCH DISHWASHER IN KITCHEN #1 AND KITCHEN-AID DISHWASHER IN KITCHEN #2 HAVE SANITIZE CYCLES.

REPORT EMAILED TO ESTABLISHMENT.

Food and Beverage Establishment Inspection Report

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 8087231022 of 01/05/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____

ANNA BOHNEN
NURSE EVALUATOR

Signed:_____

John Boettcher
Public Health Sanitarian 3
St. Paul, MN / Freeman
651-201-5076
john.boettcher@state.mn.us