Electronically Delivered

March 15, 2024

Licensee
Miles Vents Inc
10625 Rhode Island Avenue North
Brooklyn Park, MN 55445

RE: Project Number(s) SL39756015

Dear Licensee:

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

The Minnesota Department of Health completed an initial survey on February 14, 2024, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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

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

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

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.

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

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

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

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

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

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

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If you have any questions, please contact me.

Sincerely,

Renee L Anderson

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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39756	A. BUILDING: _____ B. WING _____	02/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILES VENTS INC	10625 RHODE ISLAND AVENUE N BROOKLYN PARK, MN 55445

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0 000	Initial Comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL39756015-0 On February 12, 2024, to February 14, 2024, the Minnesota Department of Health conducted an initial survey at the above provider, and the following correction orders are issued. At the time of the survey, there were two (2) residents, both of whom received services under the provider's Provisional Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours	0 460		

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0 460	Continued From page 1 per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement an effective 24-hour emergency call system for residents to request assistance for health and safety needs 24 hours per day, seven days per week. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On February 12, 2024, at 10:00 a.m., during the entrance conference, licensed assisted living	0 460		

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0 460	Continued From page 2 director/registered nurse (LALD/RN)-A stated the licensee lacked a system for residents to request assistance for health and safety needs, 24 hours per day, seven days per week. LALD/RN-A further stated the licensee's staff would be awake 24 hours per day, and the licensee's plan was for residents to verbally call out to staff if assistance for health and safety was required, and staff would be able to hear the residents from wherever they were within the facility. LALD/RN-A indicated they had a camera system to observe residents remotely when they were outside of their rooms. The licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) section 6: "Security and Monitoring" dated April 6, 2023, indicated the licensee could provide an emergency call system if needed, however, staff could hear residents in any part of the facility if residents called for help. The licensee's Scope of Services policy dated August 1, 2021, indicated licensee staffs an awake caregiver, who would be responsible for responding to the requests of the residents, for assistance with health or safety needs, at all times, including overnight, and residents would be provided with a system for accessing staff when needed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 460		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 3 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 observation, interview, and record review, the licensee failed to ensure the daily staffing schedule was posted, at the beginning of each work shift, in a central location, accessible to staff, residents, volunteers, and the public, as required, potentially affecting all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 470		

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0 470	Continued From page 4 safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The licensee lacked a posted daily staffing schedule including: - direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked; - identify the direct-care staff members' resident assignments or work location; and - be posted, after redacting direct-care staff member's resident assignments, at the beginning of each work shift in a central location in each building. On February 12, 2024, at 10:40 a.m., no posted staff schedule was observed in any area of the facility. On February 12, 2024, at 10:45 a.m., clinical nurse supervisor (CNS)-B confirmed no staffing schedule had been posted as required, and indicated licensee planned to use a white board to post the daily staffing schedule, forgot to obtain a white board, and would purchase a white board. The licensee's Staffing policy dated August 1, 2021, indicated the CNS would prepare and implement a 24-hour daily staffing plan that ensured adequate staffing to meet the residents' needs at all times, including reasonably foreseeable needs. Furthermore, licensee's daily staffing schedule, prepared by the CNS would address direct-care staff member's work	0 470		

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0 470	Continued From page 5 schedules for each direct-care staff, showing all work shifts, with days/hours worked, the direct-care staff's resident assignments or work location, and would be posted at the beginning of each shift, in a central location, accessible to staff, residents, volunteers, and the public. No further information was provided. 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: (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:	0 480		

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0 480	Continued From page 6 Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated February 12, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included completion of a two-step tuberculin skin test (TST) or other evidence of TB screening	0 660		

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0 660	Continued From page 7 such as a blood test, for one of two employees (unlicensed personnel (ULP)-C). 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: The licensee's Facility TB Risk Assessment dated June 5, 2023, indicated licensee's TB risk level was low. ULP-C was hired October 26, 2023, and provided direct care services to the licensee's residents. ULP-C's employee record contained a Baseline TB Screening Tool for Healthcare Workers, dated October 26, 2023. The record included a QuantiFERON-TB Gold Plus test dated January 20, 2024, which was positive. ULP-C's record lacked documentation of a subsequent negative chest x-ray or treatment for TB infection, prior to contact with residents. On February 13, 2024, at 10:50 a.m., licensed assisted living director/registered nurse (LALD/RN)-A verified no additional TB information was available for ULP-C. The Minnesota Department of Health (MDH) guidelines, "Regulations for Tuberculosis Control in Minnesota Health Care Settings", dated July 2013, and based on CDC guidelines, indicated a	0 660		

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0 660	Continued From page 8 TB infection control program should include the following: a team responsible for TB infection control; a facility TB risk assessment; written TB infection control procedures; and HCW education. The guidelines also indicate an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients. Baseline TB screening should be documented in the employee's record. The licensee's "Tuberculosis Screening/Prevention" policy dated August 1, 2021, indicated licensee would observe the recommended precautions related to TB prevention as identified by the CDC and the MDH, and would include the following elements: -risk assessment; -TB screening; and -staff education. Furthermore, employees would receive baseline screening upon hire to test for infection with M. tuberculosis by either TST (2 step) or IGRA, and if employees had written documentation of a positive TST or IRGA, employee's would need to provide written documentation of the results of a chest x-ray indicating no active TB disease, that was dated after the date of the positive TST or IRGA result, and if an employee did not have written documentation from above, the employee must have received a chest x-ray to exclude a diagnosis of infectious TB disease prior to having direct contact with residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 660		

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0 660	Continued From page 9 (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan (EP) with all required content. This had the potential to affect all two (2) residents receiving assisted living services, staff, and visitors.	0 680		

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0 680	Continued From page 10 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 February 12, 2024, at 11:00 a.m., the surveyor requested and reviewed the licensee's EP plan. The licensee's EP plan, dated July 2021, lacked the following required content: -development of all policies/procedures, based on assessment; and additional policies for: -handling and use of volunteers; -annual review/update of EP plan; -annual review/update of EP policies; -arrangement with other facilities (including sister facilities); -roles under a waiver declared by secretary; -EP training and testing program; -EP training program for staff (including documentation of training provided); and -annual EP testing requirements. On February 12, 2024, at 11:46 a.m., clinical nurse supervisor (CNS)-B stated the EP binder lacked the required information noted above. CNS-B further stated the licensee was not aware of all the required content that would need to be included in licensee's EP plan. In addition, CNS-B stated licensee conducted a fire drill on January 24, 2024.	0 680		

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0 680	Continued From page 11 The licensee's Emergency Preparedness policy dated August 1, 2021, indicated the licensee would have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts service. Furthermore, licensee would conduct fire drills at the residence every other month, including at least two (2) drills for each shift for a total of six (6) fire drills annually, and a disaster drill, at the residence at least annually, with documentation of drill results. In addition, licensee's EP plan would be reviewed and updated at least annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any;	0 730		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILES VENTS INC	10625 RHODE ISLAND AVENUE N BROOKLYN PARK, MN 55445

(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
0 730	Continued From page 12 (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to complete and provide to the resident, or their representative, or case worker a discharge summary with the required contents for one of one discharged resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 730		

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0 730	Continued From page 13 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3 was discharged from the facility on November 10, 2023. R3's diagnoses included: alcohol dependency, anxiety, depression, coronary artery disease, chronic venous insufficiency, diabetes mellitus with insulin dependency, diabetic peripheral neoropathy, bilateral knees degenerative joint disease, chronic kidney disease, hypentension, and deafness in right ear. R3's service plan dated March 7, 2023, indicated R3 received services including assistance with activities of daily living, medication management, daily blood pressure testing, and blood glucose monitoring. R3's progress note dated November 10, 2023, at 7:20 p.m., indicated R3 called the facility and informed staff that he would be moving out of state, to live with his sister. R3's record lacked documentation a discharge summary had been completed, to include the following: -a summary of the residents stay that included diagnoses, courses of illnesses, allergies, treatments, and therapies, and pertinent lab, radiology, and consultation results; -a final summary of the resident's status from the	0 730		

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0 730	Continued From page 14 latest assessment or review under Minnesota Statutes, section 144G.70, if applicable, which included the resident status, including baseline and current mental, behavioral, and functional status; -a reconciliation of all predischarge medications with the resident's post discharge prescribed and over-the-counter medications; and -a post discharge care plan that was developed with the resident and, with the resident's consent, the resident's representatives, which would help the resident adjust to a new living environment. The postdischarge care plan must indicate where the resident planned to reside, any arrangements that had been made for the resident's follow-up care, and any post discharge medical and nonmedical services the resident would need. On February 12, 2024, at 1:29 p.m., clinical nurse supervisor (CNS)-B stated she was not sure if a discharge summary had been completed for R3, however, they would look for the documentation. On February 12, 2024, at 1:39 p.m., licensed assisted living director/registered nurse (LALD/RN)-A and CNS-B stated R3 had called the office and informed licensee that he wanted to be closer to family and would not be coming back. LALD/RN-A and CNS-B further stated, R3's decision to move was documented on a progress note. Licensee's Discharge and Transfer of Residents policy dated August 1, 2021, indicated residents discharged or transferred from licensee would have a coordinated process for discharge or transition to another provider/setting. Furthermore, a discharge summary would be completed by the RN for all residents discharged from assisted living, a copy of the discharge	0 730		

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0 730	Continued From page 15 summary would be provided to the resident, and with the resident's consent, to the resident's representatives, resident's case manager, and would be made available to the residents health care practitioner. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
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 and interview, the licensee failed to provide or maintain fire extinguishers as required throughout the facility. This deficient condition had the ability to affect all staff, visitors, and 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	0 790		

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0 790	Continued From page 16 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: During a facility tour on February 13, 2024, at 3:10 p.m., with licensed assisted living director/registered nurse (LALD/RN)-A, the surveyor observed that the required fire extinguisher was not serviced by qualified personnel annually. At least one fire extinguisher with minimum 2-A:10-B:C rating is required to be provided, mounted, maintained, and located within 75 feet of travel throughout the facility. It was also observed documentation was not available to show the required fire extinguisher was inspected monthly by facility staff. Fire extinguishers are required to be mounted at least 4 inches off the floor and not higher than 60 inches from the floor to the top of the extinguisher. Documentation is required to demonstrate fire extinguishers have been inspected by facility personnel monthly, and annually replaced with a new extinguisher (of current year manufacture date) or serviced by a certified technician. During interview on February 13, 2024, at 3:15 p.m., LALD/RN-A, verified these deficient findings. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790		

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0 810	Continued From page 17	0 810		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview and record review, the	0 810		

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0 810	Continued From page 18 licensee failed to develop the fire safety and evacuation plan with required content, make the plan readily available, provide required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a 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 February 13, 2024, at 3:15 p.m., licensed assisted living director/registered nurse (LALD/RN)-A, provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee FSEP dated August 1, 2021, lacked the following: -The location and identification number of resident sleeping rooms shown on the FSEP floor plan. The resident sleeping room numbers are required to be provided on the FSEP floor plan for occupants to use for direction and communication during a fire or similar emergency. The numbers identifying resident rooms on the FSEP floor plan are required to match the number the location of the numbers on the doors of the resident sleeping rooms.	0 810		

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0 810	Continued From page 19 -The FSEP lacked specific fire protection actions (procedures) for residents to follow during a fire or similar emergency. During an interview on February 13, 2024, at 3:30 p.m., LALD/RN-A, stated the procedures residents are required to follow during a fire or similar emergency were not included in writing in the FSEP. TRAINING Record review indicated the licensee failed to provided evacuation training based on the facility FSEP to residents at least once per year as evident by not providing documentation in writing that training was provided to residents at least one time per year. Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and at least twice per year as evident by not providing documentation in writing that employees completed FSEP training upon hire and at least two times a year thereafter. During an interview on February 13, 2024, at 3:35 p.m., LALD/RN-A, stated the FSEP training documentation was not available for residents or employees. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month as evident by not providing documentation fire drills were provided as required. Fire drill documentation was provided for January 24, 2024, only and the shift it was	0 810		

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0 810	Continued From page 20 completed was not identified. During an interview on February 13, 2024, at 3:45 p.m., LALD/RN-A, stated the only documentation of fire drills available was on January 24, 2024. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01490 SS=D	144G.63 Subd. 4 Training required relating to dementia All direct care staff and supervisors providing direct services must demonstrate an understanding of the training specified in section 144G.64. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received the required hours of initial dementia care training for one of two employees (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-C was hired October 26, 2023, and provided direct care services to residents.	01490		

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01490	Continued From page 21 ULP-C's employee record lacked documentation of at least eight hours of initial dementia training within 160 working hours of the employment start date including: (1) an explanation of Alzheimer's disease and other dementias; (2) assistance with activities of daily living; (3) problem solving challenging behaviors; (4) communication skills; and (5) person-centered planning and service delivery. On February 13, 2024, at 9:55 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated ULP-C had not completed the required initial dementia care training. LALD/RN-A further stated "we do not have an assisted living with dementia care license". In addition, LALD/RN-A stated staff dementia training would only be required if a facility was licensed as an assisted living facility with dementia care. The licensee's Dementia Training policy, dated August 1, 2021, indicated all staff providing care would be knowledgeable in how to provide safe, effective services related to dementia. Furthermore, direct care employees would be required to complete eight (8) hours of dementia training within 160 hours of the employment start date in the following topics: -an explanation of Alzheimer's disease and other dementias; - assistance with activities of daily living; - problem solving challenging behaviors; -communication skills; and - person-centered planning and service delivery. No further information was provided.	01490		

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01490	Continued From page 22 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01490		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure staff documented the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed, for one of two residents (R1). 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	01760		

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01760	Continued From page 23 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 had diagnoses including, but not limited to schizoaffective disorder, alcohol use disorder, bipolar disorder, and diabetes mellitus type 2. R1's home health aide care plan dated October 25, 2023, indicated R1 was receiving services including assistance with activities of daily living, meals, medication set-up by the registered nurse (RN), medication administration, behavior monitoring, and homemaking. On February 13, 2024, at 8:30 a.m., unlicensed personnel (ULP)-C was observed administering oral medications, from a pre-filled medication pill box, to R1 in the kitchen area of the facility. ULP-C placed the medications in a medication cup, handed the medication cup to R1, and R1 took the medication orally. ULP-C handed R1 water to swallow the medications. During medication administration, surveyor observed a capsule fall onto the kitchen floor. ULP-C placed R1's medication pill box back into the cabinet, locked the cabinet, and washed her hands. ULP-C left the capsule on the floor, did not identify the capsule was not administered, did not document the medication administration, or follow up to meet the resident's needs when medication was not administered as prescribed. R1's prescriber orders dated February 1, 2024, included the following scheduled medications: -acetaminophen 325 mg (milligram) - one tablet every six hours as needed- indicated for pain; -amlodipine besylate 10 mg - one tablet by mouth daily- indicated for hypertension;	01760		

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01760	Continued From page 24 -aspirin 81 mg - one tablet by mouth daily- indicated for type 2 diabetes mellitus; -atorvastatin 40 mg - one tablet by mouth daily - one capsule by mouth daily- indicated for type 2 diabetes; -chlorhexidine 0.12% solution - 15 milliliter by mouth twice daily, swish and spit- indicated for gingivitis; -Culturelle - one capsule by mouth daily- indicated for infection prevention; -fluoxetine 10 mg - one capsule by mouth daily- indicated for bipolar mood disorder; -fluoxetine 40 mg - one capsule by mouth daily- indicated for bipolar mood disorder; -ibuprofen 600 mg - one tablet by mouth every six hours as needed- indicated for pain; -metformin 100 mg - one tablet by mouth twice daily with a meal- indicated for type 2 diabetes mellitus; -naloxone 4 mg/0.1 mg - instill one spray in one nostril as a single dose. May repeat every two to three minutes in alternating nostrils as directed- indicated for opioid overdose; -naltrexone 500 mg - one tablet by mouth daily- indicated for alcohol use disorder; -oxybutynin 5 mg ER - one tablet by mouth daily- indicated for over-active bladder; -risperidone 3mg - two tablets by mouth at bedtime- indicated for schizoaffective disorder; and -Vitamin D3 25 mcg (microgram) - one capsule by mouth daily- indicated for vitamin supplement. R1's medication management plan dated June 5, 2023, included the following: -weekly medication set-up by the RN; -medication administration three times daily by the ULP; and -medication education to ULP as needed.	01760		

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01760	Continued From page 25 R1's medication administration record (MAR) for February 2024, lacked ULP-C's full signature, date, time, and initials, for all morning medication administered, the reason why medication administration was not completed as prescribed, and documentation of any follow-up procedures provided to meet the resident's needs when medication was not administered as prescribed. On February 13, 2024, at 9:30 a.m., ULP-C stated she was aware one of R1's oral medication capsules had fallen on the kitchen floor; however, she was too scared to pick the oral medication capsule up off the floor. ULP-C further stated she was unable to identify which oral medication capsule fell onto the floor. On February 13, 2024, at 9:30 a.m., licensed assisted living director (LALD)/RN-A and clinical nurse supervisor (CNS)-B stated ULP-C did not notify the RN when a medication was not administered, document the reason why medication administration was not completed as prescribed, nor document any follow-up procedures. LALD/RN-A and CNS-B further stated, staff should notify RN if a medication was not given, place the medication in an envelope, and document why a medication was not administered as prescribed. On February 13, 2024, at 9:37 a.m., CNS-B stated the licensee lacked a policy for medication that had fallen on the floor, and that policy would be something licensee would need to put in place. The licensee's Medication Documentation policy dated August 1, 2021, indicated each medication administered by licensee would be documented in the resident's clinical record, documentation	01760		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01760	Continued From page 26 would be complete, accurate, and legible. Furthermore, resident's needs would be met related to the medication management plan. In addition, if the administration of one or more medications was not completed, staff would document the following: -the reason why the medication was not administered; -follow up procedures to meet the resident's needs in compliance with the medication management plan; -appropriate notification to RN supervisor or other persons as instructed regarding missed dosages; and -medication error report, if appropriate. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure documentation of medication setup by the registered nurse (RN) included all the required content for one of one resident (R1). This practice resulted in a level two violation (a	01770		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39756	A. BUILDING: _____ B. WING _____	02/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILES VENTS INC	10625 RHODE ISLAND AVENUE N BROOKLYN PARK, MN 55445

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01770	Continued From page 27 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: During the entrance conference on February 12, 2024, at 10:00 a.m., licensed assisted living director (LALD)/RN-A stated the licensee provided medication management services which included weekly medication setup by the RN for their residents. R1's home health aide care plan dated October 25, 2023, indicated R1 received services including: assistance with activities of daily living, meals, medication set-up by the RN, medication administration, behavior monitoring, and homemaking. On February 13, 2024, at 8:30 a.m., unlicensed personnel (ULP)-C was observed administering oral medications, from a pre-filled medication pill box, to R1 in facility kitchen area. ULP-C placed the medications in a medication cup, handed the medication cup to R1, and R1 took the medication orally. ULP-C handed R1 water to swallow the medication. R1's record lacked documentation by the licensed nurse at the time of medication setup to include documentation of the dates of medication setup, quantity of dose setup, and the name/signature of the person completing medication setup. On February 13, 2024, at 10:45 a.m., LALD/RN-A	01770		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39756	A. BUILDING: _____ B. WING _____	02/14/2024

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MILES VENTS INC	10625 RHODE ISLAND AVENUE N BROOKLYN PARK, MN 55445

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01770	Continued From page 28 stated she set up medications for all the licensee's residents and initialed the medication setup on the medication administration record daily, for each resident. LALD/RN-A further stated, the required documentation content required above had been lacking from R1's clinical record. The licensee's Medication Documentation policy dated August 1, 2021, indicated each medication administered by licensee would be documented in the resident's clinical record, documentation would be completed promptly, accurate, and legible. Furthermore, resident's needs would be met related to the medication management plan. In addition, licensee would document medication setup according to the following: -date of medication setup; -name of medication; -quantity of dose; -times to be administered; -route of administration; and -name/title of person completing medication setup. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39756	A. BUILDING: _____ B. WING _____	02/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILES VENTS INC	10625 RHODE ISLAND AVENUE N BROOKLYN PARK, MN 55445

(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
01910	Continued From page 29 disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include quantity, and names of staff and other individuals involved in the disposition of medications for one of one discharged resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R3's service plan dated March 7, 2023, indicated R3 received assistance with activities of daily living, medication management, daily blood pressure testing, and blood glucose monitoring.	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39756	A. BUILDING: _____ B. WING _____	02/14/2024

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MILES VENTS INC	10625 RHODE ISLAND AVENUE N BROOKLYN PARK, MN 55445

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01910	Continued From page 30 The licensee's discharged or deceased resident roster dated January 23, 2024, indicated R3 was discharged from licensee's facility on November 10, 2023. R3's medical record included a progress note dated, November 10, 2023, which indicated R3 would be moving out of state, to live with his sister. R3's medication administration record dated November 2023, included the following scheduled medications: -cerovite senior (multivitamin) - one tablet by mouth daily- indicated for vitamin supplement; -clopidogrel 75 mg (milligram) - one tablet by mouth daily- indicated for heart health; -Cymbalta (delayed release) 60 mg- one tablet by mouth daily- indicated for depression; -gabapentin 600 mg - one tablet by mouth three times daily- indicated for control of seizures and restless leg syndrome; -Glucophage 1000 mg - one tablet by mouth twice daily- indicated for diatetes mellitus type 2; -folic acid 1 mg - one tablet by mouth daily- indicated for anemia treatment or prevention; -Levemir 70 units subcutaneous - at bedtime- indicated for diabetes mellitus type 2; -Lipitor 40 mg - one tablet by mouth at bedtime- indicated for high cholesterol; -pantoprazole sodium 40 mg- one tablet by mouth daily- indicated for stomach acid reducer; -Seroquel 400 mg - one tablet by mouth at bedtime- indicated for treatment of mental heath conditions; -Toprol XL 50 mg - one tablet by mouth daily- indicated for hypertension; -vitamin B1 100 mg - one tablet by mouth daily- indicated for vitamin supplement;	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39756	A. BUILDING: _____ B. WING _____	02/14/2024

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MILES VENTS INC	10625 RHODE ISLAND AVENUE N BROOKLYN PARK, MN 55445

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01910	Continued From page 31 -Victoza 6mg/1ml (mililiter) solution - insert 1.2 mg under the skin daily- indicated for diabetes mellitus type 2; and -Xalatan 0.005% solution - one drop in the eye at bedtime- indicated for treatment of eye pressure. An email dated November 20, 2023, at 3:10 p.m., indicated office assistant (OA)-E sent an email to R3's licensed social worker (LSW) indicating, R3's medications were mailed to the LSW's office on November 17, 2023. An email dated November 20, 2023, at 3:46 p.m., indicated the LSW sent an email to OA-E indicating R3's medications were received. R3's record lacked documentation of medication disposition upon discharge from facility to include the medication's name, strength, prescription number as applicable, quantity, and names of staff and other individuals involved in the disposition, for fourteen (14) out of fourteen (14) prescribed medications. On February 12, 2024, at 1:29 p.m., clinical nurse supervisor (CNS)-B indicated R3's medical record lacked a medication disposition record. CNS-B stated licensee communicated with R3's LSW through email regarding R3 medication disposition. CNS-B further stated they did not document the name, quantity, or strength of the medications mailed to R3's LSW. The licensee's Disposition and Disposal of Medication policy dated August 1, 2021, indicated disposal and disposition of discontinued medications for residents receiving the medication management program would be completed in a safe manner, by appropriate personnel. Furthermore, licensee would	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39756	A. BUILDING: _____ B. WING _____	02/14/2024

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01910	Continued From page 32 document the following information in the clinical record: -name, strength, and prescription number, as applicable; -quantity; and -name(s)/signature(s) of staff or other individuals involved in disposition. No further information was provided. Time period for correction: Seven (7) days	01910		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, and interview, the licensee failed to ensure the required notice was posted at the main entry way of the facility to display statutory language to disclose electronic monitoring activity. This had the potential to affect all two (2) residents residing in the assisted living facility, staff, and any visitors of the licensee. 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	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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03090	Continued From page 33 or has potential to affect a large portion or all of the residents). The finding include: On February 12, 2024, at 10:00 a.m., upon arriving at the facility, the outside front entrance and just inside the front entrance were observed to lack the required signage posted with the required verbiage regarding electronic monitoring. On February 12, 2024, at 10:40 a.m., the licensed assisted living director/registered nurse (LALD/RN)-A and clinical nurse supervisor (CNS)-B toured the front entrance of the establishment, with the surveyor, and verified there was signage posted indicating electronic monitoring at facility entrance, but posted signage did not include the required verbiage regarding electronic monitoring. LALD/RN-A stated she was not aware of the verbiage requirement. The licensee's Electronic Monitoring policy, dated August 1, 2021, directed signs would be installed at each facility entrance with the required verbiage regarding electronic monitoring, and signs would be accessible to visitors. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090		

Environmental Health
Food, Pools, and Lodging
625 Robert St. N
St. Paul
651-201-5000

Type: Full
Date: *02/12/24*
Time: 11:00:00
Report: 1031241032

Food and Beverage Establishment Inspection Report

Location:
Miles Vents Inc
10625 Rhode Island Avenue Nort
Brooklyn Park, MN55443
Hennepin County, 27

Establishment Info:
ID #: 0042407
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/24

Operator:

Phone #: 7632055880
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

4-302.12A ***** Priority 2 *****

MN Rule 4626.0705A Provide a readily accessible food temperature measuring device to ensure attainment and maintenance of food temperatures.

ESTABLISHMENT DOES NOT HAVE A THIN PROBE THERMOMETER.

Comply By: 02/15/24

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 MISSING IRREVERSIBLE MEASURING DEVICE OR WAX TEST STRIPS. PROVIDE IRREVERSIBLE MEASURING DEVICE OR WAX STRIPS AND MEASURE UTENSIL TEMPERATURE (160F REQUIRED) AT REGULAR INTERVALS.

Comply By: 02/15/24

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.

ESTABLISHMENT DOES NOT HAVE SANITIER TESTING KIT ON SITE. PROVIDE AND USE TEST KIT TO CHECK SANITIZER CONCENTRATION.

Comply By: 02/15/24

4-600 Cleaning Equipment and Utensils

4-602.13

MN Rule 4626.0855 Clean all non-food-contact surfaces of equipment at a frequency necessary to preclude accumulation of soil residues.

REFRIGERATOR AND BOTTOM OF STOVE HAVE FACTORY SHIPPING PLASTIC ON APPLIANCES. REMOVE PLASTIC FROM SURFACES.

Comply By: 02/26/24

6-300 Physical Facility Numbers and Capacities

6-303.11A

MN Rule 4626.1470A Provide at least 10 foot candles (108 LUX) of light intensity at a distance of 30 inches from the floor in the walk-in refrigeration units, dry food storage areas, and in other areas during periods of cleaning.

LIGHTS ARE BURNT OUT IN KITCHEN CEILING FIXTURE. REPLACE LIGHTS.

Comply By: 02/26/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.

CABINET DOOR UNDER 2-COMP SINK WILL NOT STAY SHUT/LATCHED. REPAIR DOOR SO IT STAYS SHUT/LATCHED.

Comply By: 02/26/24

Surface and Equipment Sanitizers

Quaternary Ammonia: = 150 at Degrees Fahrenheit
Location: Sanitizer Wipes
Violation Issued: No

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

Food and Equipment Temperatures

Process/Item: Cold Hold/Milk
Temperature: 38 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: No

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

Inspection conducted by Chris F.

All violations discussed with Ose during the inspection.

NOTES:

ALL DISHES NEED TO BE WASHED/RINSED/SANITIZED IN DISH MACHINE; DO NOT USE DISH MACHINE FOR STORAGE.*

- MICROWAVE/EXHAUST FAN HAS RED LIGHT SAYING RESET FILTER. CLEAR RED LIGHT; LOOK UP IN GE WEBSITE OR GOOGLE HOW TO RESET/CLEAR LIGHT.

- Establishment has a residential kitchen (4626.0506(G)(2)) Same-day service only. No saving and reheating of foods or preparation of foods the day prior to eating. Any remaining food from meals to be removed/discarded at end of day.

- Employee food needs to be labeled and separated from residents food.

- Gloves should be used for single-purpose only; switch gloves whenever leaving kitchen to do other work.

- Cutting boards should be utilized as food contact surfaces and not stacked on top of each other.

- - Establishment needs to check dish washer utensil temperature weekly (160F required). If utensil temp not reaching 160F, use washer to wash/rinse and sink basin with sanitizer solution to sanitize dishes then air dry, as discussed during inspection.

- 2-Comp sink has right basin designated for handwashing and the right basin for product washing/prep sink.

- When preparing food from raw, make sure to use a thermometer to check temperatures.

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Environmental Health inspection report number 1031241032 of 02/12/24.

Certified Food Protection Manager: Felix O Agene

Certification Number: FM118435 Expires: 08/19/26

Inspection report reviewed with person in charge and emailed.

Signed: _____

Ose Agene
Person in Charge

Signed: _____

Chris Foster
Public Health Sanitarian II
Freeman Office Building
651-983-8760
chris.j.foster@state.mn.us

Report #: 1031241032

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Environmental Health
Food, Pools, and Lodging
625 Robert St. N
St. Paul

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

Date 02/12/24
Time In 11:00:00
Time Out

	Address	City/State	Zip Code	Telephone
Miles Vents Inc	10625 Rhode Island Avenue Nort	Brooklyn Park, MN	55443	7632055880

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0042407		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

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

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

Food Recalls:

Person in Charge (Signature) **Date:** 02/12/24

Inspector (Signature)