Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery

February 20, 2025

Licensee
Integra Home Health Professionals LLC
4532 Boone Avenue North
New Hope, MN 55428

RE: License Number 416425
Health Facility Identification Number (HFID) 34776
Project Number(s) SL34776015

Dear Licensee:

On February 4, 2025, The Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed August 7, 2024, and the follow-up survey completed October 21, 2025. This follow-up survey found the facility to be in substantial compliance. Based on these findings, the condition(s) on the license were removed effective February 20, 2025.

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.

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

Sincerely,

Rick Michals

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

JMD

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered

November 27, 2024

Licensee
Integra Home Health Professionals LLC
4532 Boone Avenue North
New Hope, MN 55428

RE: Conditional License Number 416425
Health Facility Identification Number (HFID) 34776
Project Number(s) SL34776015

Dear Licensee:

On October 21, 2024, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on August 7, 2024. Based on the follow-up survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.20, MDH is issuing a conditional assisted living facility license for 90-days, due to expire on **February 25, 2025**.

MDH may assess fines based on the level and scope of the orders outlined below. The total amount of **potential** fines that may be assessed related to these correction orders is $500.00. **MDH is not imposing these fines against your license at this time.**

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on August 7, 2024, found not corrected at the time of the October 21, 2024, follow-up survey and/or subject to penalty assessment are as follows:

0820 - Fire Protection And Physical Environment - 144g.45 Subd. 2 (g) - $500.00

The details of the violations noted at the time of this follow-up survey completed on October 21, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to

comply with the correction orders and immediately correct any reissued orders outlined on the state form; however, plans of correction are not required to be submitted for approval. **If corrections are not made, MDH may impose fines as described above and in accordance with Minnesota Statutes 144G.**

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

CONDITIONAL LICENSE ISSUED:

MDH will issue a conditional assisted living facility license for Integra Home Health Professionals LLC, for 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if Integra Home Health Professionals LLC is in substantial compliance.

The following conditions apply on the conditional assisted living facility license:

a. **General Contractor:** Integra Home Health Professionals LLC must provide the following to Benjamin J. Zwart (Benjamin.Zwart@state.mn.us) via email within 21-days of the date of this notice:
    i. Name
    ii. License Number
    iii. Contact Information

b. **Egress Window Requirements:** Integra Home Health Professionals LLC will replace at least one window in occupied resident sleeping rooms #2, #3, and #4, and unoccupied resident sleeping room #1 meeting the minimum size requirements.
    i. Must have a minimum openable width of no less than 20 inches

ii. Must have a minimum openable height of no less than 20 inches
iii. Must have a total openable area of no less than 648 square inches (4.5 square feet)
iv. Must have a windowsill height of no more than 48 inches from the floor to the clear opening
v. All measurements must be achieved under normal operation of opening window without the use of a key, tool or special knowledge

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL LICENSE PERIOD:
MDH will determine if Integra Home Health Professionals LLC is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional license period. If MDH determines Integra Home Health Professionals LLC is in substantial compliance on the follow up survey, MDH will remove the conditions from Integra Home Health Professionals LLC's assisted living facility license, and Integra Home Health Professionals LLC will correct any outstanding violations identified during the survey. If Integra Home Health Professionals LLC is not in substantial compliance on the follow-up survey, MDH may take additional enforcement action, up to and including immediate temporary suspension and revocation, as authorized by Minn. Stat. § 144G.20.

REQUESTING A HEARING:
Pursuant to Minn. Stat. §144G.20, Subd. 18, the licensee may appeal an action against the license under this section. The licensee must request a hearing no later than 15 business days after licensee receives notice of the action.

To submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRD-Appeals-Form.

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

If you have any questions, please contact Benjamin J. Zwart directly at: 651-201-3715.

Sincerely,

Rick Michals

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34776	A. BUILDING: _____ B. WING _____	R 10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INTEGRA HOME HEALTH PROF LLC	4532 BOONE AVENUE NORTH NEW HOPE, MN 55428

(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 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#34776015-1 On October 21, 2024, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on August 7, 2024. At the time of the survey, there were 3 active residents; 3 receiving services under the Assisted Living license. As a result of the revisit, the following orders were reissued and/or issued.	{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 SUBDIVISION 1-3.	
{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: (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: No further action required.	{0 480}		
{0 660} SS=E	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: No further action required.	{0 660}		
{0 700} SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in	{0 700}		

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{0 700}	Continued From page 2 compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: No further action required.	{0 700}		
{0 820} SS=F	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedrooms with the minimum window opening meeting the minimum state standard for egress. This had the potential to affect some residents, staff, and visitors.	{0 820}		

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{0 820}	Continued From page 3 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 October 21, 2024, surveyor conducted a revisit to follow-up on orders issued pursuant to a survey completed on August 7, 2024. On October 21, 2024, at 10:35 a.m. per phone conversation, licensed assisted living director (LALD)-A stated the windows have not been replaced, were working with a contractor, and awaiting plan approval from Department of Labor to move forward with the window install. On October 21, 2024, at 10:45 a.m. survey staff toured the facility with unlicensed personnel (ULP)-G. During the tour, survey staff asked ULP-G to open the windows in the resident bedrooms for measurement. The noncompliant measurements were as follows: Bedroom #1 (unoccupied): window measured 34 inches clear width, 15 inches clear height, and 510 square inches total open area. Bedroom #2: window measured 26 inches clear width, 16 inches clear height, and 416 square inches total open area. Bedroom #3: window measured 26 inches clear width, 16 inches clear height, and 416 square inches total open area. Bedroom #4: window measured 33.5 inches clear width, 19 inches clear height, and 636.5 square	{0 820}		

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{0 820}	Continued From page 4 inches total open area. The windows in bedrooms #1, #2, #3, and #4 did not meet the minimum requirements for opening height and did not meet the minimum requirements for total openable area. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. Survey staff explained to ULP-G and LALD-A that at least one window in each bedroom in a state-licensed facility must meet the minimum state fire code standard for an egress window to be a complying bedroom for resident occupancy. ULP-G and LALD-A verbally confirmed the findings. No Further information was provided.	{0 820}		
{01290} SS=E	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction	{01290}		

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{01290}	Continued From page 5 does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: No further action required.	{01290}		
{01460} SS=E	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: No further action required.	{01460}		
{01620} SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be	{01620}		

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{01620}	Continued From page 6 completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: No further action required.	{01620}		
{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 and the Office of Ombudsman for Mental Health and Developmental Disabilities. (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	{01640}		

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{01640}	Continued From page 7 when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: No further action required.	{01640}		
{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: No further action required.	{01760}		
{01880} SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced	{01880}		

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{01880}	Continued From page 8 by: No further action required.	{01880}		
{01890} SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in 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: No further action required.	{01890}		
{02310} SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: No further action required.	{02310}		

Electronically Delivered

August 30, 2024

Licensee
Integra Home Health Professionals, LLC
4532 Boone Avenue North
New Hope, MN 55428

RE: Project Number(s) SL34776015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 7, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

In accordance with Minn. Stat. § 144G.31, Subd. 4(a)(5), MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. MDH may impose a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. MDH also may impose a

fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

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

St - 0 - 0495 - 144g.41 Subd. 1 (14) - Minimum Requirements - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a

hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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.

If you have any questions, please contact me.

Sincerely,

Jessie Chenze, Supervisor
State Evaluation Team
Email: Jessie.Chenze@state.mn.us
Telephone: 218-332-5175 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
	34776	A. BUILDING: _____ B. WING _____	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INTEGRA HOME HEALTH PROF LLC	4532 BOONE AVENUE NORTH NEW HOPE, MN 55428

(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: SL34776015 On August 5, 2024, through, August 7, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were three residents receiving services under the provider's Assisted Living Facility license. Immediate correction order(s) were identifed on August 5, 2024, and August 6, 2024, issued for SL34776015, tag identification 0495 and 0820 respectively. On August 8, 2024, the immediacy of correction order 0820 was removed, however non-compliance remained at a scope and level of I. Immediacy of correction order 0495 was not	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 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 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 evaluators ' 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 SUBDIVISION 1-3.	

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0 000	Continued From page 1 removed prior to survey exit.	0 000		
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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated August 5, 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		
0 495 SS=I	144G.41 Subd. 1 (14) Minimum Requirements (14) provide staff access to an on-call registered nurse 24 hours per day, seven days per week	0 495		

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0 495	Continued From page 2 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure staff had access to a registered nurse (RN) 24 hours per day, seven days per week. This had the potential to affect all residents receiving assisted living services. This resulted in an immediate correction order issued on August 5, 2024. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Order correction made on August 7, 2024 changing identifier of NP-B to NP-D. The finidngs include: During the entrance conference of August 5, 2024, at 11:24 a.m., licensed assisted living director (LALD)-A stated clinical nurse supervisor (CNS)-C was the primary nurse for the facility. LALD-A said CNS-C was out of the country "right now" and added that she (LALD-A) could contact CNS-C for a fee. LALD-A stated they have a back up nurse who is a nurse practitioner (advanced RN degree/(NP-D) as well as another backup RN (RN-B). RN-B was not able to be reached the first week of August, and NP-D stated she would be the licensee's on-call RN.	0 495		

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0 495	Continued From page 3 LALD-A stated NP-D has another job, and did not work full time for the licensee. On August 5, 2024, at 12:36 p.m. the surveyor called NP-D and left a voice message requesting a return call. On August 5, 2024, at 12:46 p.m. NP-D called the surveyor and stated she was currently working and would be available after 8:00 p.m. this evening. NP-D added she would be at the facility "tomorrow" (August 6, 2024) to give an injection. NP-D immediately called the surveyor back and said it might be closer to 8:30 p.m., before she could get to the facility. On August 5, 2024, at 12:49 p.m. LALD-A stated "right now" the licensee did not have a nurse available until after 8:00 p.m. On August 5, 2024, at 12:51 p.m. CNS-C stated NP-D's phone number was available for staff to contact NP-D in the computer system used at the facility. CNS-C also stated she was available via phone call, and verified she was out of the country. On August 5, 2024, at 1:59 p.m., LALD-A stated RN-B was at the facility. The surveyor spoke with RN-B. RN-B stated she was hired last Tuesday to be backup at this facility. RN-B stated she originally planned to be out of the state this week, but her plans changed, and she was now available until 4:00 p.m. However, she would not be available for the remainder of the week. The licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) dated August 1, 2022, noted: -availability of licensed (RN/LPN (licensed	0 495		

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0 495	Continued From page 4 practical nurse) staff (in addition to an RN who is required to be accessible to the staff 24/7) was blank. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE As of survey exit on August 7, 2024, immediacy of this order remains in place.	0 495		
0 660 SS=E	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 ensure the provider established and maintained a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) for two of four employees	0 660		

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0 660	Continued From page 5 (nurse practitioner (advanced registered nurse (RN) degree/(NP)-D, clinical nurse supervisor (CNS)-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 a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: The facility's TB risk assessment was completed on August 10, 2023, and was noted to be a "zero" (low risk level). NP-D NP-D was hired on July 16, 2024, to provide direct care and services to the licensee's residents and oversight of the licensee's employees. On August 5, 2024, at 12:46 p.m., NP-D stated she would be at the facility "tomorrow" (August 6, 2024) to give an injection. NP-D immediately called the surveyor back and said it might be closer to 8:30 p.m., before she could get to the facility. On August 7, 2024, at 9:41 a.m., licensed assisted living director (LALD)-A and unlicensed personnel (ULP)-F stated NP-D was at the facility last evening (August 6, 2024). NP-D's employee record included:	0 660		

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0 660	Continued From page 6 -Baseline TB Screening Tool for Health Care Workers (HCWs) dated July 16, 2024 -noted on TB blood test form: QuatinFERON TB-Gold test result dated November 29, 2023. (230 days from hire, due on or after April 17, 2024, until July 19, 2024). On August 7, 2024, at 10:39 a.m., LALD-A reviewed NP-D's record and confirmed NP-D's TB blood test was obtained greater than 90 days from hire. CNS-C CNS-C was hired on December 3, 2019, to provide direct care and services to the licensee's residents and oversight of the licensee's employees. On August 5, 2024, at 11:24 a.m., LALD-A stated CNS-C was the CNS for the licensee. CNS's employee record included: -TB blood test: QuatinFERON TB-Gold test result dated December 17, 2019 -CXR dated December 2, 2019, negative. CNS-C's employee record lacked evidence of a TB screening tool. On August 6, 2024, at 2:27 p.m., CNS-C's employee record was reviewed with LALD-A. LALD-A confirmed CNS-C's employee record did not include a TB screening. LALD-A stated she would contact CNS-C in attempts to locate TB Screen. On August 7, 2024, at 9:45 a.m., the surveyor inquired if CNS-C was able to locate TB screen for ULP-E. LALD-A said she was still looking for CNS-C's TB screening.	0 660		

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0 660	Continued From page 7 On August 6, 2024, at approximately 3:15 p.m., LALD-A continued to attempt to locate CNS-C's TB screening, however LALD-A was not able to locate CNS-C's TB screening. The licensee's Tuberculosis Screening/Prevention policy dated August 1, 2021, noted (name) of facility observed the recommended precautions related to TB prevention as identified by the Centers for Disease Control and Prevention (CDC) and the Minnesota Department of Health (MDH). Baseline testing was completed on hire for all direct care providers and anyone who visits residents (including volunteers). Employees received baseline TB screening upon hire to test for infection with M. tuberculosis. Baseline screening included an assessment for TB history and current TB symptoms. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, screen (no symptoms of active TB disease) and a negative IGRA or TST (first step) dated within 90 days before hire. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 660		
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable	0 700		

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0 700	Continued From page 8 relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure resident's personal health and medical information was kept private. This had the potential to affect three of three residents (R2, R4, R3) residing at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R2 On August 6, 2024, at 7:20 a.m., the surveyor observed unlicensed personnel (ULP)-E preparing R2's morning medication. ULP-E compared R2's medications with R2's electronic medication administration record (EMAR) on a computer positioned on a desk in the open commons/living area. ULP-E left the computer screen up with R2's EMAR visible while ULP-E went to the dining area/ kitchen to administer R2's medication. On August 6, 2024, at 7:24 a.m., ULP-E returned to the computer to document some medications that were declined in R2's EMAR. ULP-E left the	0 700		

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0 700	Continued From page 9 computer screen up with R2's EMAR visible when ULP-E returned R2's medication to the medication closet by the kitchen entry door of the facility. On August 6, 2024, at 7:30 a.m., ULP-E stated "normally" he is at the computer the entire time and R2's EMAR was not left visible. ULP-E stated he logs out of the computer. ULP-E confirmed R2's EMAR should not have been left visible. R4 On August 6, 2024, at 7:45 a.m., the surveyor observed ULP-E go to the desk in the open common's/ living area, log into the computer and bring up R4's EMAR on the computer screen. ULP-E left the computer screen visible and walked to the medication closet near the kitchen entry door and gathered R4's medication. ULP-E returned to the computer to prepare R4's medication. On August 6, 2024, at 7:54 a.m., ULP-E went to the kitchen, washed, and dried his hands, and administered R4's medication. R4's EMAR was visible on the computer screen. On August 6, 2024, at 7:56 a.m., ULP-E closed R4's EMAR and logged out of the computer. R3 On August 6, 2024, at 9:48 a.m., ULP-F was logged into the computer positioned on a desk in the open commons/living area. ULP-F left the computer screen up with R3's EMAR visible while ULP-F went to the dining area/ kitchen to administer R3's medication. On August 6, 2024, at 9:58 a.m., registered nurse (RN)-B and the surveyor observed R3's EMAR on	0 700		

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0 700	Continued From page 10 the computer screen. RN-B stated computer screens should be closed and not left visible. RN-B added she did not train the ULPs at this facility, but computer screens should also be pointed away from others when in use. The licensee's Privacy of Protected Health Information policy dated August 1, 2021, noted staff would maintain confidentiality of protected health information in the office and when doing business on behalf of (name of facility). No clinical records or personal health information about residents would be accessible in public areas of the office. The licensee's Resident Confidentiality policy dated August 1, 2021, noted all resident information, including but not limited to personal, financial and medical data, would be kept confidential and released only in the following situations: -to authorized persons with an appropriate release of information -according to law -to employees or contractors of (name of facility) -to another home care provider, a health care practitioner or provider, or an inpatient facility that requires information to provide services to the resident, but only the information that is necessary to provide services -to representatives of the commissioner authorized to survey or investigate home care provider. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700		

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0 820	Continued From page 11	0 820		
0 820 SS=I	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedrooms with the minimum window opening meeting the minimum state standard for egress. This had the potential to affect some residents, staff, and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	0 820		

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0 820	Continued From page 12 On August 06, 2024, from approximately 10:15 a.m. to 10:45 a.m., survey staff toured the facility with licensed assisted living director (LALD)-A. During the tour, survey staff asked LALD-A to open the windows in the resident bedrooms for measurement. The noncompliant measurements were as follows: OCCUPIED SLEEPING ROOMS: Bedroom 2: Window measured 26 inches clear width, 16 inches clear height, and 416 square inches total open area for each window. Bedroom 3: Window measured 26 inches clear width, 16 inches clear height, and 416 square inches total open area for each window. Bedroom 4: Window measured 33.5 inches clear width, 19 inches clear height, and 636.5 square inches total open area for each window. UNOCCUPIED SLEEPING ROOMS: Bedroom 1: One window measuring 34 inches clear width, 15 inches clear height, and 510 square inches total open area. The windows in bedrooms 1, 2, 3 and 4 did not meet the minimum requirements for opening height. The windows in bedrooms 1,2, 3 and 4 did not meet the minimum requirements for total openable area. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window.	0 820		

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0 820	Continued From page 13 Survey staff explained to LALD-A that at least one window in each bedroom in a state-licensed facility must meet the minimum state fire code standard for an egress window to be a complying bedroom for resident occupancy and that an immediate correction order was issued for the above findings. LALD-A stated they understood the requirements. TIME PERIOD FOR CORRECTION: Immediate.	0 820		
01290 SS=E	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was affiliated with the assisted living license for one of three employees (registered nurse (RN-B).	01290		

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01290	Continued From page 14 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 than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: RN-B was licensed as a RN by the Minnesota State Board of Nursing effective November 25, 2008. RN-B was hired on July 16, 2024, to provide direct care and services to the licensee's residents and oversight of the licensee's employees. R2's medication administration record (MAR) entry dated August 6, 2024, noted Zepbound (weight loss) 0.5 milliliter (ml) 5 micrograms (mg) was administered by RN-B on August 6, 2024. On August 6, 2024, at 9:58 a.m., registered nurse (RN)-B and the surveyor observed ULP-F administer R3's medication. Upon review of the licensee's NETStudy Roster, RN-B was affiliated to health facility identification number (HFID) 34406, the licensee's home care (comprehensive) identification and was cleared in NETStudy 2.0. RN-B's record lacked documentation of a cleared background study affiliated with the facility's correct HFID.	01290		

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01290	Continued From page 15 On August 5, 2024, at 1:23 p.m., licensed assisted living director (LALD)-A stated the provider had not completed a background study affiliated with license for RN-B. LALD-A reviewed the NETStudy form she had printed and stated the background studies completed this year were for the wrong HFID number. LALD-A said she was not sure why the wrong HFID number was used, adding she would call about it. The licensee's Recruitment and Hiring policy dated August 1, 2021, noted the employment process included: -the criminal background check would be submitted to Minnesota Department of Human Services (DHS) following the step-by-step procedure established by DHS: -the director or designee was responsible for initiating the criminal background study for new employees -NETStudy 2.0 (or current version) would be used for the background check -the employee would be directed to locations established by DNS to obtain fingerprint scans -employees would be instructed that photographic identification would be required -employee/study subjects may enter their own background study demographic information using the facility identification code provided -results of the background study would be maintained in the employee's personnel file. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		

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01460	Continued From page 16	01460		
01460 SS=E	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure staff providing services completed orientation to assisted living facility licensing requirements and regulations, before providing services, for two of four employees (nurse practitioner (advanced registered nurse (RN) degree/(NP)-D, RN-B). 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 than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: The findings include: NP-D NP-D was hired on July 16, 2024, to provide direct care and services to the licensee's	01460		

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01460	Continued From page 17 residents and oversight of the licensee's employees. On August 5, 2024, at 12:46 p.m. NP-D stated she would be at the facility "tomorrow" (August 6, 2024) to give an injection. NP-D immediately called the surveyor back and said it might be closer to 8:30 p.m., before she could get to the facility. On August 7, 2024, at 9:41 a.m., licensed assisted living director (LALD)-A and unlicensed personnel (ULP)-F stated NP-D was at the facility last evening (August 6, 2024). NP-D's record included Guide to Assisted Living completed November 9, 2023. RN-B RN-B was hired on July 16, 2024, to provide direct care and services to the licensee's residents and oversight of the licensee's employees. On August 6, 2024, at 9:58 a.m., RN-B and the surveyor observed R3's EMAR on the computer screen. RN-B stated computer screens should be closed and not left visible. RN-B's record included Guide to Assisted Living completed November 7, 2023. NP-D and RN-B lacked an employee record and documentation of orientation, completed before providing services, including: -Overview of Assisted Living statutes -Home care/Assisted Living bill of rights -Handling of resident/clients' complaints, reporting of complaints, where to report -Consumer advocacy services the Office of	01460		

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01460	Continued From page 18 Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services -Review of type of Assisted Living services the employee would provide and provider's scope of license. On August 7, 2024, at 10:53 a.m., LALD-A confirmed NP-D and RN-B's Educare (electronic training software system) training was completed prior to their employment for the licensee. LALD-A stated she thought Educare training done within the year would meet the requirement. The licensee's Professional Staff Orientation policy dated August 1, 2021, noted all professional staff providing assisted living services through (name of facility) would be prepared for their responsibilities related to assessments, service/care plan preparation, supervision, medication management and delegation. The Orientation Checklist would be used to document and verify the completion of orientation for each employee. Upon completion of the orientation, the signed/dated Orientation Checklist would be retained in the employee record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01460		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring	01620		

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01620	Continued From page 19 (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) completed ongoing resident reassessments that did not exceed 90 days for two of two residents (R2, 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 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	01620		

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01620	Continued From page 20 of the residents). The findings include: R2 R2's diagnoses include developmental disability, depression, anxiety, insomnia, and explosive behavior. R2's service plan dated March 3, 2022, indicated R2 received medication administration. On August 6, 2024, at 7:20 a.m., the surveyor observed unlicensed personnel (ULP)-E preparing R2's morning medication. R2's record included a 90-day assessment dated February 17, 2024. R2's record included an assessment dated June 24, 2024. (128 days between assessments). On August 6, 2024, at 10:45 a.m., R2's record was reviewed with RN-B. RN-B stated R2's record did not contain an assessment completed within or before 90 days as required. R3 R3 began receiving services on February 23, 2024. R3's diagnoses include below the knee bilateral amputation, schizophrenia (chronic brain disorder, combination of hallucinations, delusions, and disordered thinking and behavior,) bipolar disorder (extreme mood swings, extreme excitement episodes or extreme depressive feelings), anxiety, and panic attacks of delusions (strongly held false beliefs with conflict with reality).	01620		

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01620	Continued From page 21 R3's service plan dated February 23, 2024, indicated R3 received medication administration. On August 6, 2024, at 9:48 a.m., the surveyor observed ULP-E administer R3's medication. R3's record included a 14-day assessment dated March 8, 2024. R3's record included a 90-day assessment dated June 28, 2024, which included a note, assessment was done on June 8, 2024, but on the computer on June 28, 2024. (92 days between assessments). On August 6, 2024, at 10:56 a.m., R3's record was reviewed with RN-B. RN-B confirmed R3's 90-day assessment was completed late. On August 6, 2024, at 11:02 a.m., RN-B reviewed R4's record. RN-B stated R4's last assessment was completed 91 days from the previous assessment. RN-B said she was not sure what happened (why assessments were completed late). RN-B stated assessments can be completed early but not late. On August 7, 2024, at approximately 10:45 a.m., licensed assisted living director (LALD)-A stated she knows clinical nurse supervisor (CNS)-C liked to use paper assessments. The surveyor explained to LALD-A that RN-B was not able to find any other assessments in resident records. The licensee's Assessment and Reassessment policy dated August 1, 2021, noted ongoing resident reassessment must be conducted by an RN and cannot exceed 90 days from the last date of assessment.	01620		

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01620	Continued From page 22 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
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 and the Office of Ombudsman for Mental Health and Developmental Disabilities. (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 services plans were revised to reflect the current services provided for one of two residents (R3).	01640		

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01640	Continued From page 23 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: R3's diagnoses include below the knee bilateral amputation (BKA), schizophrenia (chronic brain disorder, combination of hallucinations, delusions, and disordered thinking and behavior,) bipolar disorder (extreme mood swings, extreme excitement episodes or extreme depressive feelings,) anxiety, and panic attacks of delusions (strongly held false beliefs with conflict with reality). R3's service plan dated February 23, 2024, indicated R3 received wound dressing. R3's Individualized Treatment and Therapy Plan dated April 1, 2024, included: -home health aide (unlicensed personnel/ULP)- clean would on his RLE (Right leg extremity) with normal saline, and cover with 4x4 Mepilex daily. Notify RN (registered nurse) sign and symptoms of infections, such as fever, redness, swelling, drainage, and tenderness. R3's record included: Supervision: wound care, active date April 1, 2024 - RN monitor open area on his right lower extremities related to postop (after operation) BKA -ended July 17, 2024, wound healed. (service	01640		

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01640	Continued From page 24 ended) On August 6, 2024, at 12:28 p.m., R3's record was reviewed with RN-B. RN-B stated R3's service plan should have been updated when wound care was no longer needed. RN-B stated she was not able to find anything in R3's record that an update was in progress for R3's service plan. RN-B confirmed R3's service plan had not been revised as required. The licensee's Service Plan policy dated August 1, 2021, noted the service plan must be revised, if needed, based on resident review or reassessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
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.	01760		

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01760	Continued From page 25 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure the steps of the medication administration process was followed for one of two employees, unlicensed personnel (ULP)-E. In addition, the licensee failed to ensure medications were administered as ordered for one of two resident (R2) who received medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 R2's diagnoses include developmental disability, depression, anxiety, insomnia, and explosive behavior. R2's service plan dated March 3, 2022, included a medication management plan which indicated R2 received medication administration four times daily. R2's medication administration record (MAR) dated August 1, 2024, through August 6, 2024, included: -vitamin D3 25 micrograms (mcg) 1000 units (supplement) -calcium plus D3, two tablets daily (supplement) -Certavite, one tablet daily (supplement)	01760		

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01760	Continued From page 26 -fluticasone nasal 50 mcg spray daily (nasal inflammation) -Senna-time 8.6 milligrams (mg) (constipation) -risperidone two mg (behaviors) -sertraline 100 mg (depression) -valacyclovir 500 mg daily (anti-viral) -Vaseline moisture daily (dry skin). R2's prescriber orders dated April 9, 2024, included the above medications. MEDICATION ADMINISTRATION PROCESS On August 6, 2024, at 7:11 a.m., the surveyor observed ULP-E remove R2's medication from a locked medication area and bring the medication to a desk in the commons area near the computer. ULP-E reviewed R2's online MAR with medications adding the "nurse" changes medications. ULP-E prepared the following medication as he reviewed R2's MAR: -calcium with vitamin D two tablets daily. ULP-E placed the medication into medication cup. ULP-E documented medication: verified, administered. -Vaseline moisture, apply topically to all open sores twice daily. ULP-E stated, "will apply later", documented medication: verified, administered -Certavite daily, ULP-E documented medication: verified, administered -omeprazole 40 mg twice daily, ULP-E documented medication: verified, administered -risperidone 2 mg in morning, ULP-E documented medication: verified, administered -Senna-time 8.6 mg twice daily, ULP-E documented medication: verified, administered -sertraline, 100 mg, two tablets daily, ULP-E documented medication: verified, administered -valacyclovir 500 mg daily, ULP-E documented a circle and wrote "noted" (to indicate administration issue) on MAR	01760		

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	34776	A. BUILDING: _____ B. WING _____	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01760	Continued From page 27 -fluticasone nasal 50 mcg spray, one to two sprays in each nostril daily, ULP-E documented "not in rotation" (on MAR) -vitamin D3 25 micrograms (mcg) daily, ULP-E documented "refill needed" on MAR. R4 R4's diagnoses include schizophrenia (chronic brain disorder, combination of hallucinations, delusions, and disordered thinking and behavior), aggressive behavior, anxiety, and depression. On August 6, 2024, at 7:48 a.m., the surveyor observed ULP-E review R4's MAR and document MiraLAX 17 grams verified and administered. ULP-E took the MiraLAX container to a counter in the kitchen and mixed a capful (measurement) of MiraLAX into a glass of juice, stirred and gave the juice which contained medication to R4. On August 6, 2024, at 8:59 a.m., ULP-E stated the process was to document administered as he prepared medication. ULP-E said there might be an occasion that a resident would decline a medication, but ULP-E could go back to the MAR and correct it, "it is a two click process" (changing medication administration on the MAR). On August 6, 2024, at 12:28 p.m., registered nurse (RN)-B stated medication administration should be done after medications are administered, not before medication administration. ADMINISTERED AS ORDERED On August 6, 2024, at 7:25 a.m., ULP-E stated R2's fluticasone and valacyclovir needed to be removed from R2's MAR. ULP-E said R2 was no longer getting those medications. ULP-E added he knew this because clinical nurse supervisor	01760		

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01760	Continued From page 28 (CNS)-C had told him of this medication change. On August 6, 2024, at 10:06 a.m., CNS-C stated R2's nasal spray (fluticasone) should have been given if it was available (surveyor observed R2's nasal spray in medication closet August 5, 2024, at 12:11 p.m.). CNS-C added R2's nasal spray had not been discontinued. On August 6, 2024, at approximately 11:15 a.m., RN-B stated she was not concerned with R2 not getting valacyclovir as it was a medication that may have needed to be renewed, not a permanent medication. The licensee's Medication Documentation policy dated August 1, 2021, noted documentation of medication administration and medication set up would be completed promptly. Documentation would be complete, accurate and legible. The licensee's Prescriber's Orders policy dated August 1, 2021, noted the RN was responsible for implementing medication and treatment orders or for delegating the orders to the appropriate paraprofessional. The licensee's Mediation Orders policy dated August 1, 2021, noted (name) of facility would administer medications prescribed by the authorized prescriber and in accordance with all the rights defined in the Home Care Bill of Rights and in the Health Insurance Portability and Accountability Act. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		

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01880	Continued From page 29	01880		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medication was secure and permitted access to only authorized personnel for one of one refrigerator being used to store medication. In addition, the licensee failed to ensure medication was secured in a locked area for two of three residents (R2, R4). Further, the licensee failed to ensure refrigerated medication was maintained at manufacturer recommended temperatures by failing to monitor and document medication refrigerator temperatures for one of one medication refrigerator. 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: SECURE MEDICATION STORAGE On August 5, 2024, at 12:11 p.m., the surveyor toured the facility with licensed assisted living director (LALD)-A including a review of the	01880		

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01880	Continued From page 30 medication refrigerator located in the dining area of the facility. The medication refrigerator was not locked and contained one unopened Zepbound 0.5 milligram (mg) (weight loss) pen for R2. LALD-A said the medication refrigerator was new, and stated the refrigerator should be locked/secured. R2 On August 6, 2024, at 7:07 a.m., the surveyor observed unlicensed personnel (ULP)-E removed R2's medication from a locked medication area and bring the medication to a desk in the open commons area near the computer. ULP-E went to the kitchen to discard some water and to get a pair of gloves. R2's medication was not secure and R2's medication was not within ULP-E's view. On August 6, 2024, at 7:16 a.m., the surveyor observed R2's medication at the computer, R2 sitting at the dining table, ULP-E in the kitchen. On August 6, 2024, at 7:19 a.m., the surveyor observed ULP-E walk away from the desk where R2's medications were and went into the kitchen. R2's medication as not secure and not within ULP-E's view. On August 6, 2024, at 7:30 a.m., ULP-E stated he is normally near medication the "entire" time adding he left to look for R2's vitamin D3. ULP-E confirmed R2's medications were to be secured. R4 On August 6, 2024, at 7:46 a.m., the surveyor observed ULP-E remove R4's medication from the locked medication closet. ULP-E placed the medication cards and a container of Miralax (bowel health) on the desk in the open common's room near the computer. R4 was eating at the	01880		

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01880	Continued From page 31 dining room table. ULP-E took R4's medication cards and Miralax back to the medication closet to check that the door was locked. ULP-E returned to the desk and prepared R4's morning medication and placed them into a medication cup. ULP-E took the medication cup and the container of Miralax to R4 who was seated at the dining room table. The surveyor observed R4's medication cards by the computer when ULP-E administered R4's medication. ULP-E's back was to R4's medication cards. R4's medication was not secured. On August 6, 2024, at 7:56 a.m., ULP-E logged out of the computer and returned R4's medications to the locked medication closet. On August 6, 2024, at 9:58 a.m., registered nurse (RN)-B stated medications are to be secured. MANUFACTURER'S RECOMMENDATION On August 5, 2024, at 12:11 p.m., the surveyor asked LALD-A for the current temperature of the medication refrigerator. LALD-A looked in the refrigerator and stated there was not a thermometer in the medication refrigerator. LALD-A stated the temperature of the medication refrigerator was not being monitored, adding prior to yesterday (August 4, 2024) medication had been stored in the food refrigerator. LALD-A confirmed the temperature of the medication refrigerator was not being monitored as required. The refrigerator contained: -one unopened Zepbound 0.5 mg pen for R2 The manufacturer's instructions for Zepbound injection pen dated November 2023, indicated to store unopened Zepbound in the refrigerator at 36-46 degrees Fahrenheit (F). Do not freeze your pen. If the pen has been frozen, throw the pen	01880		

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01880	Continued From page 32 away and use a new pen. The licensee's Storage/Control of Medications policy dated August 1, 2021, noted medications are stored in a secured medication cabinet. Only authorized nursing personnel have access to the locked cabinet. In addition, medications requiring refrigeration are clearly labeled and stored in an enclosed container or area separated from food. Temperature is maintained at 35-40 degrees. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in 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 date time sensitive medications for one of three 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	01890		

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01890	Continued From page 33 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On August 5, 2024, at 12:02 p.m., the surveyor toured the facility with licensed assisted living director (LALD)-A, including a review of the locked medication closet. LALD-A observed and confirmed the following: -R2's two opened bottles of Refresh Optive (dry eyes) solution did not have a label which indicated the date the eye solution was opened or would expire. Directly after the above observation LALD-A looked at one of the Refresh eye solutions and stated the medication would expire December 2025, the manufacturer's expiration date printed on the eye solution. LALD-A stated she was not aware R2's Refresh eye solution was a time sensitive medication. The manufacturer's instructions were reviewed with LALD-A. LALD-A removed one of R2's Refresh eye solution bottles, adding so "they (unlicensed personnel/ ULP) do not use it in the meantime." The manufacturer's instructions for Refresh Optive dated September 2022, noted discard 90 days after opening. The licensee's Storage/Control of Medications policy dated August 1, 2021, noted medication is labeled completely and legibly. The medication label should contain the expiration date for time-dated drugs. In addition, the licensed nurse was responsible for dating time-sensitive medications when opened. No further information was provided.	01890		

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01890	Continued From page 34 TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for one of one resident (R3) with hospital-style bed rails. 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: R3's diagnoses include below the knee bilateral amputation, schizophrenia (chronic brain disorder, combination of hallucinations, delusions, and disordered thinking and behavior,) bipolar disorder (extreme mood swings, extreme excitement episodes or extreme depressive	02310		

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02310	Continued From page 35 feelings,) anxiety, and panic attacks of delusions (strongly held false beliefs with conflict with reality). R3's service plan dated February 23, 2024, indicated R3 received assist with transfers from bed to chair, wheelchair (WC), or WC to bed. R3's assessment dated June 28, 2024, included: -resident used hospital bed with two side rails (bed rails) -resident has bilateral below knee amputation (BKA) and need side rail to sit up and maneuver -bed rails needed due to BKA -education had been provided to the resident/responsible party of the risks and benefits of the bed rails and verbalized understand -the bed rail meets FDA (Food and Drug Administration) guidelines. On August 6, 2024, at 9:30 a.m., the surveyor observed R3 sitting in his hospital bed while unlicensed personnel (ULP)-F emptied R3's bedside urinal. R3 self-transferred into wheelchair from hospital bed. There was a bed rail in the raised position on the wall side of R3's bed and a bedrail in the lowered position on the side of bed R3 exited from. On August 5, 2024, at 11:42 a.m., R3's assessment was reviewed with registered nurse (RN)-B. RN-B stated she was not able to find bedrail measurements in R3's assessment. RN-B said "probably" clinical nurse supervisor (CNS)-C was not aware of the requirement of including the bedrail measurements in assessments. R3's record lacked a comprehensive assessment on the use of an assistive device to include	02310		

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02310	Continued From page 36 measurements. The licensee's Side Rail Use policy dated August 1, 2021, noted, the registered nurse (RN) was responsible to ensure that the side rails in use are of a safe design and properly maintained. The Guidance for Industry and FDA (Federal and Drug Administration) Staff: Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment dated March 10, 2006, noted, reducing the risk of entrapment involves a multi-faceted approach that includes bed design, clinical assessment and monitoring, as well as meeting patient, resident, and family needs for vulnerable patients in most health care settings - hospitals, long term care facilities, and at home. Therefore, comprehensive bed safety programs in these settings will likely involve input from manufacturers as well as facility staff. Recognizing that not all hospital beds present a risk of entrapment, and that this risk may vary depending on the patient, FDA encourages manufacturers and facilities to work together to develop bed safety programs to evaluate and, if needed, mitigate entrapment risk. When evaluating the safe use of a hospital bed, component or accessory, manufacturers and caregivers should recognize that the risk for entrapment may increase if a hospital bed system is used for purposes, or used in a care setting, not intended by the manufacturer. Evaluating the dimensional limits of gaps in hospital beds may be one component of a bed safety program which includes a comprehensive plan for patient and bed assessment. FDA recommends that healthcare facilities conduct a risk-benefit analysis to ensure that steps taken to mitigate the risk of entrapment do not create different, unintended risks or reduce clinical benefits	02310		

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02310	Continued From page 37 available to patients using legacy beds. Such steps may include checking with bed system manufacturers to identify compatible mattresses, rails, and accessories. The FDA "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe". No further information provided. TIME PERIOD OF CORRECTION: Two (2) days	02310		

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

DEPARTMENT OF HEALTH

Type: Full
Date: *08/05/24*
Time: 10:00:00
Report: 1031241193

Food and Beverage Establishment Inspection Report

Location:
Integra Home Health Prof Llc
4532 Boone Avenue North
New Hope, MN55428
Hennepin County, 27

Establishment Info:
ID #: 0038644
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7635379530
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

4-302.14 ***** Priority 2 *****

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

ESTABLISHMENT DOES NOT HAVE SANITIZER TESTING KIT ON SITE. PURCHASE KIT AND TEST SANI CONCENTRATION (50-200PPM BLEACH, 150-400PPM QUAT)

Comply By: 08/08/24

6-300 Physical Facility Numbers and Capacities

6-301.12 ***** Priority 2 *****

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

KITCHEN HANDSINK MISSING PAPER TOWELS.

Comply By: 08/08/24

4-100 Equipment Construction Materials

4-101.19

MN Rule 4626.0495 Remove non-food-contact surfaces of equipment that are exposed to splash, spillage, or other food soiling, or that require frequent cleaning, that are not constructed of a corrosion-resistant, non-absorbent, and smooth material.

SHINY BUBBLE WRAP USED IN DRAWERS UNDER UTENSILS. REMOVE BUBBLE WRAP. CLEAN DRAWERS AND PLACE UTENSILS ON CONTACT PAPER.

Comply By: 08/26/24

Type: Full
Date: *08/05/24*
Time: 10:00:00
Report: 1031241193
Integra Home Health Prof Llc

Food and Beverage Establishment Inspection Report

6-100 Physical Facility Construction Materials

6-101.11A1

MN Rule 4626.1325A1 Provide smooth, durable, and easily cleanable floor, wall and ceiling surfaces.

AREA BETWEEN RANGE AND HOOD NOT CLEANABLE. REPLACE MISSING TILES OR COVER AREA IN STAINLESS STEEL. USE 100% SILICONE TO SEAL SIDES OF STAINLESS.

Comply By: 08/26/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

MN Rule 4626.1520A Clean and maintain all physical facilities clean.

1. SHELVES AND DRAWERS HAVE BUILDUP OF FOOD DEBRIS OR GREASE. CLEAN ALL SHELVES AND DRAWERS WITH FOOD DEBRIS/GREASE ON THEM.

2. COUNTER BACKSPLASH PANELS HAVE BUILDUP OF FOOD DEBRIS. CLEAN BACKSPLASH PANELS.

Comply By: 08/26/24

Surface and Equipment Sanitizers

Quaternary Ammonia: = 400 at Degrees Fahrenheit
Location: Chlorox Wipes
Violation Issued: No

Quaternary Ammonia: = 400 at Degrees Fahrenheit
Location: Lyson Wipes
Violation Issued: No

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

Food and Equipment Temperatures

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

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

Nurse Evaluator on site: Cindi Casey

All violations discussed with PIC during the inspection.

DISH MACHINE TEMPERATURE INFORMATION WAS REQUESTED, BUT NOT PROVIDED BY PIC. SEND THIS INFORMAITON OVER ASAP.

NOTES:

- 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.

- Establishment does not have pasteurized eggs and does not prepare eggs for consumption under 145F. Purchase pasteurized eggs if intending to serve eggs undercooked.

- Make sure to datemark any prepared cold items that are kept in refrigerator.

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

- Cutting boards should be utilized as food contact surfaces and not counters or plates.

- - 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 left basin designated for handwashing and the right basin for product washing/prep sink.

- When preparing food, make sure to use a thin-probe 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 1031241193 of 08/05/24.

Certified Food Protection Manager idil A Farah

Certification Number: FM11740 Expires: 01/03/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Idil Farah
Person in Charge

Signed: _____
Chris Foster
Public Health Sanitarian II
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