Electronically Delivered

March 23, 2023

Licensee
Comfort Care Center LLC
3236 Brunswick Avenue South
Edina, MN 55416

RE: Project Number(s) SL37711015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on February 1, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

The correction order documentation should include the following:

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

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

correction order receipt date.

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

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

Please address your cover letter for reconsideration requests to:

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

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

Sincerely,

Jonathan Hill, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jonathan.hill@state.mn.us
Telephone: 651-201-3993 Fax: 651-281-9796

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37711	A. BUILDING: _____ B. WING _____	02/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE CENTER LLC	3236 BRUNSWICK AVENUE SOUTH EDINA, MN 55416

(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 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: SL37711015 On January 30, 2022 , through February 1, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were two (2) residents, all of whom received services under the provider's Assisted Living Facility.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facility license. 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.	
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: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated February 2, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses	0 680		

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0 680	Continued From page 2 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 observation, interview, and record review, the licensee failed to have a written emergency preparedness plan with all the required content. This had the potential to affect the four residents receiving services under the assisted living license, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 680		

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0 680	Continued From page 3 The findings include: During the entrance conference on January 30, 2023, at 10:00 a.m., a request was made to view the licensee's emergency preparedness plan. The licensee's plan lacked the following required content: -current, all-hazards approach facility assessment -description of the population served by licensee -process for emergency preparedness (EP) cooperation with state and local EP officials/organizations -subsistence needs for staff and residents during an emergency -procedure for tracking staff and residents -development of all policies/procedures, based on assessment, and additional policies for: -sheltering in place -handling medical documents-handling and use of volunteers -arrangement with other facilities (including sister facilities) -development of a communication plan, including primary and alternate means for communication -methods for sharing information -EP training and testing program -EP training program for staff (including documentation of training provided) -annual EP testing requirements. In addition, residents were not provided emergency exit diagrams and emergency exit diagrams were not posted on each of two (2) floors. On January 30, 2023, at 11:15 a.m., the licensed assisted living director (LALD)-A stated the current emergency preparedness plan lacked all required content. LALD-A further explained the	0 680		

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0 680	Continued From page 4 licensee did not develop a disaster program to apply specifically to the facility and in addition, an evacuation plan, education/training, and drills were not completed. No further information was provided.	0 680		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed provide adequately rated portable fire extinguishers as required for the facility and failed to maintain fire extinguishers in accordance with MN State Fire Code as required by MN Statute 144G.45 Subd.2 (a)(2). This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 790		

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0 790	Continued From page 5 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On January 31, 2023, at approximately 10:00 a.m., survey staff toured the facility with the Licensed Assisted Living Director (LALD)-A. It was observed that each of the fire extinguishers provided were 1-A:10-BC rated and did not have at least one 2-A:10-B:C rated fire extinguisher as required by MN Statute 144G.45. It was observed that the fire extinguisher did not have an annual maintenance tag showing that it had been inspected as required by MN State Fire Code and lacked records to show the required monthly visual inspections were performed for portable fire extinguishers. LALD-A visually verified this deficient finding at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.	0 800		

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0 800	Continued From page 6 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the ability to affect a limited number of staff 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 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On January 31, 2023, at approximately 10:00 a.m., survey staff toured the facility with the Licensed Assisted Living Director (LALD)-A. During the facility tour, survey staff observed the following items: In the lower-level resident bed room #3 and #4, it was observed that the window screen was missing. In the lower-level family room, it was observed that the supply air grille was hanging out of the ceiling with the missing bolt. In the lower-level family room, it was observed	0 800		

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0 800	Continued From page 7 that the ceiling light cover was missing. During the interview, LALD-A stated that the current ceiling light fixture is too dim, so he removed the cover to make it brighter. In the lower-level family room, it was observed that the half-burned papers were inside the fireplace. Also observed was that the stacks of paper were stored next to the fireplace and the cigarette-making kit with tobacco mix was placed on a table near the fireplace. During the interview, LALD-A stated that they do not use the fireplace and he was not aware of the paper burning. In the lower-level bathroom, the ceiling exhaust fan was not working and was rusted. During the interview, LALD-A stated that one of the residents kept closing the exhaust vent. In the upper-level bathroom, it was observed that only one light bulb was working out of four bulbs. The ceiling paint was bubbled and the supply air grilles on the floor were badly rusted. In the upper-level resident bedroom #1, it was observed that the multiple plug strips were daisy chained to provide power to two heaters and other electrical equipment creating a possible fire hazard. In upper-level bedroom #2, it was observed that the window was covered with plastic and did not fully close. The window gap was approximately 4 inches and was filled with a bedsheet to keep cold air away. In upper-level bedroom #2, it was observed that the window screen was missing, and the ceiling light fixture cover was removed.	0 800		

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0 800	Continued From page 8 In the upper-level common space, it was observed that the multiple plug strips were daisy-chained with an extension cord feeding off one of the plug strips to provide power to two heaters and four fish tanks. The plug strips were all attached by a multi-tap plug device with all these elements creating a fire hazard. On the front porch, it was observed that the burnt used cigarettes were being disposed of without a proper disposal container. It was also observed that a gasoline can for the snow blower was located right next to the smoking chair creating a possible fire hazard. LALD-A visually verified this deficient finding at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation.	0 810		

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0 810	Continued From page 9 (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 observation, interview and record review, the licensee failed to develop a fire safety and evacuation plan with required elements; failed to provide required employee training on fire safety and evacuation; failed to provide training to residents capable of assisting in their own evacuation and failed to conduct required evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect	0 810		

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0 810	Continued From page 10 a large portion or all of the residents). Findings include: An interview and record review of the available documentation were conducted on January 31, 2023, at approximately 10:00 a.m., with the Licensed Assisted Living Director (LALD)-A on the fire safety and evacuation plan, fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. Record review of the available documentation indicated that the fire safety and evacuation plan was not maintained. Record review of the available documentation indicated that the licensee did have the unedited copy of the Emergency Preparedness in Assisted Living with some provisions for the fire safety requirement. During the interview, LALD-A stated that he did not implement the Emergency Preparedness in Assisted Living Plan to the facility-specific requirement, and he was not aware of any provisions in the fire safety and evacuation plan for this requirement. LALD-A verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan. During interview, LALD-A verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of the available documentation indicated that the fire safety and evacuation plan did not include the identification of unique or unusual resident needs for movement or evacuation in the procedures for resident	0 810		

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0 810	Continued From page 11 movement, evacuation, or relocation during a fire or similar emergency. During interview, LALD-A stated he was not aware of any provisions in the fire safety and evacuation plan for this requirement. Record review of available document indicated that employees did not receive trainings on the fire safety and evacuation plans upon hiring and at least twice per years thereafter as required by statute. During interview, LALD-A verified that there were no further documented training for the staffs on the fire safety and evacuation plan as required by statute. Record review of the available documentation did not indicate that the licensee provides annual training to residents who can assist in their own evacuation on the proper actions to take in the event of a fire to include movement, evacuation, or relocation as required by statute. Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month as required by statute. Provided documentation indicated that the drills were conducted on 11-05-22 at 12:00 p.m. with no further drills being documented. LALD-A verified that there were no further documented drills for the facility and verified this deficient condition. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following	01470		

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01470	Continued From page 12 topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of 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; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37711	A. BUILDING: _____ B. WING _____	02/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE CENTER LLC	3236 BRUNSWICK AVENUE SOUTH EDINA, MN 55416

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01470	Continued From page 13 topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide orientation to assisted living licensing requirements and regulations prior to providing services for one of two employees (unlicensed personnel (ULP)-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 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 on May 1, 2022 to provide direct care and services to residents of the facility. On January 31, 2023 at approximately 8:00 a.m., a licensed assisted living director (LALD)-A, who	01470		

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01470	Continued From page 14 also provided direct care and services to residents, was observed adminstering medication, providine activities of daily living, and preparing meals for residents (R1 and R2).. LALD-A stated ULP-C provided the same services but was not working at the time of the survey. ULP-C's record lacked documentation of orientation to assisted living regulations as follows: - Overview of Assisted Living statutes - Review of provider's policies and procedures - Handling emergencies and using emergency services - Reporting maltreatment of vulnerable adults or minors - Assisted Living bill of rights - Handing of resident complaints, reporting of complaints, where to report - Consumer advocacy services - Review of types of Assisted Living services the employee will provide and provider's scope of license - Orientation to each specific resident and services provided - Dementia training required for all direct care staff and supervisors - Initial 8 hours of dementia care training within 160 hours. On January 31, 2023, at 10:00 a.m., LALD-A stated ULP-C's record lacked orientation to assisted living regulations. LALD-A stated employees were provided with the assisted living orientation but was not documented in their respected records. The licensee lacked policies to include the new Assisted Living Licensure requirements, that went	01470		

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	37711	A. BUILDING: _____ B. WING _____	02/01/2023

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01470	Continued From page 15 into effect August 1, 2021. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		
01620 SS=D	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 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 interview and record review, the licensee failed to ensure the registered nurse	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37711	A. BUILDING: _____ B. WING _____	02/01/2023

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01620	Continued From page 16 (RN) conducted ongoing resident monitoring and reassessment not to exceed 90 calendar days from the last date of assessment 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 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted on September 4, 2022. On January 30, 2023, at 10:00 a.m. during the entrance conference, the licensed assisted living director (LALD)-A identified a registered nurse (RN)-B as the primary nurse responsible for completion of documentation and assessments of residents residing in te facility. R1's record contained a Comprehensive Assessment/Licensed Services dated September 7, 2022, and a fourteen (14) day assessment dated and signed on September 9, 2022, by RN-B The 14 day assessment was not complete and only indicated "no changes". No other assessments were provided for R1. On January 31, 2023, at approximately 12:45 p.m., LALD-A indicated licensee's expectation are: -an initial assessment upon admission, another -within 14 days of the initial assessment -with any change of condition or within	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01620	Continued From page 17 -no longer than 90 days from the previous assessment. LALD-A stated licensee had missed completing R1's assessments within the required time frame. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		

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

Type: Full
Date: *02/01/23*
Time: 12:50:00
Report: 1013231036

Food and Beverage Establishment Inspection Report

Location:
Comfort Care Center Llc
3236 Brunswick Avenue South
St Louis Park, MN55416
Hennepin County, 27

Establishment Info:
ID #: 0038670
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6127034183
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.

4-700 Sanitizing Equipment and Utensils

4-702.11 ** Priority 1 **

MN Rule 4626.0900 Sanitize utensils and food contact surfaces of equipment before use, after cleaning.

FACILITY'S DISH MACHINE WAS NOT WORKING. PER STAFF WARE WAS WASHED WITH SOAP THEN DRIED WITH TOWELS. COMPLY WITH ABOVE RULE. DISCUSSED WARE WASHING PROCEDURES AND HELPED STAFF MAKE SANITIZER SOLUTION MEASURING 50 PPM CHLORINE. MDH GUIDANCE PROVIDED.

Comply By: 02/01/23

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.

RAW MEATS ARE COOKED AT THE FACILITY AND TCS FOODS ARE STORED ON-SITE. NO FOOD PROBE THERMOMETER WAS AVAILABLE. COMPLY WITH ABOVE RULE.

Comply By: 02/04/23

2-100 Supervision

2-102.12AMN

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

NO MN CFPM WAS EMPLOYED AT THE FACILITY. COMPLY WITH ABOVE RULE. STAFF STATED THEY WERE IN THE PROCESS OF GETTING CERTIFIED.

Comply By: 05/01/23

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

FACILITY'S KITCHEN DISH MACHINE AND REFRIGERATOR WERE NOT WORKING. STAFF POSTED SIGNS ON THE EQUIPMENT STATING THEY WERE NOT WORKING. COMPLY WITH ABOVE RULE.

Comply By: 02/02/23

4-600 Cleaning Equipment and Utensils

4-601.11C

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

GRIME AND DEBRIS WERE INSIDE THE BROKEN DISH MACHINE. CLEAN AND MAINTAIN CLEAN. COMPLY WITH ABOVE RULE.

Comply By: 02/01/23

4-600 Cleaning Equipment and Utensils

4-602.11D5

MN Rule 4626.0845D5 Clean equipment used for the storage of packaged or unpackaged food, such as a reach-in refrigerator, at a frequency which precludes accumulation of soil residues.

FOOD DEBRIS AND GRIME WERE INSIDE THE FREEZER LOCATED IN THE GARAGE. CLEAN AND MAINTAIN CLEAN. COMPLY WITH ABOVE RULE.

Comply By: 02/01/23

4-600 Cleaning Equipment and Utensils

4-602.12

MN Rule 4626.0850 Clean the food contact surfaces of cooking and baking equipment and interior cavities of microwave ovens at least every 24 hours.

FOOD DEBRIS AND GRIME WERE INSIDE THE KITCHEN MICROWAVE. CLEAN AND MAINTAIN CLEAN. COMPLY WITH ABOVE RULE.

Comply By: 02/01/23

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

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

GREASE AND GRIME WERE ON THE WALL AND CABINETS NEAR THE STOVE AND MICROWAVE. CLEAN AND MAINTAIN CLEAN. COMPLY WITH ABOVE RULE.

Comply By: 02/01/23

Food and Equipment Temperatures

Food and Beverage Establishment Inspection Report

Process/Item: Milk
Temperature: 39 Degrees Fahrenheit - Location: Kitchen refrigerator 2
Violation Issued: No

Process/Item: Yogurt
Temperature: 39 Degrees Fahrenheit - Location: Kitchen refrigerator 2
Violation Issued: No

Process/Item: Chicken
Temperature: 19 Degrees Fahrenheit - Location: Kitchen freezer 1
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	1	1	6

The inspection was completed with the operator and reviewed with MDH Nurse Evaluator M. Bruess.

The establishment has a residential kitchen and serves food that is prepared that day. The kitchen has wood cabinets, laminate floor, wall papered and painted walls, solid counter top, and a textured ceiling.

A two basin sink is located in the kitchen. One basin is designated for hand washing.

A residential dish machine is located in the kitchen. The dish machine was not working so manual ware washing with a sanitizer solution was demonstrated.

Discussed hand washing, ware washing, staff illness policy, temperature control, final cook temperatures, cleaning, serving highly susceptible populations, and food handling procedures.

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1013231036 of 02/01/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Mohamed Mohamud
Operator

Signed: JM
Jerry Malloy
Public Health Sanitarian
FPLS Metro
651-201-3998
jerry.malloy@state.mn.us