Electronically Delivered

October 10, 2024

Licensee
Ace Homes Inc
3425 77th Avenue North
Brooklyn Park, MN 55443

RE: Project Number(s) SL35375015

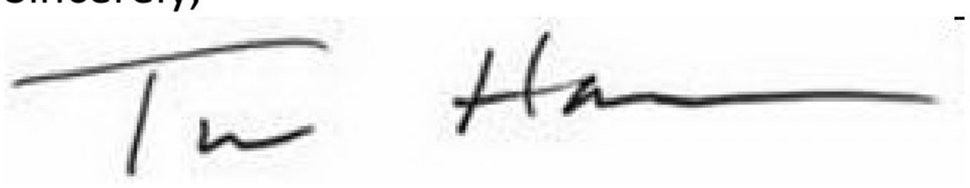
Dear Licensee:

On September 4, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the June 12, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,



Tim Hanna, Supervisor
State Evaluation Team
Email: Tim.Hanna@state.mn.us
Telephone: 507-208-8982 Fax: 1-866-890-9290

HHH

Electronically Delivered

July 12, 2024

Licensee
Ace Homes Inc
3425 77th Avenue North
Brooklyn Park, MN 55443

RE: Project Number(s) SL35375015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 12, 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 . . ."

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 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

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,

Kelly Thorson

Kelly Thorson, Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.us
Telephone: 320-223-7336 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
	35375	A. BUILDING: _____ B. WING _____	06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACE HOMES INC	3425 77TH AVENUE NORTH BROOKLYN PARK, MN 55443

(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: SL35375015 On June 10, through June 12, 2024, the Minnesota Department of Health conducted an intial survey at the above provider, and the following correction orders are issued. At the time of the survey, there were three residents all receiving services under the provider's Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours	0 460		

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0 460	Continued From page 1 per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On June 10, 2024, at 10:30 a.m., owner/housing manager (O/HM)-A stated they do not have a way	0 460		

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0 460	Continued From page 2 for residents to summon staff 24/7 and was not aware of this requirement. O/HM-A further stated all the residents are independent and just go to or call out for staff with any questions or needs. The licensee's Staffing policy dated July 23, 2021, indicated residents are provided with a means to request assistance for health and safety needs 24 hours/day 7 days/week; during night shifts, the home health aide will respond to resident requests for assistance as soon as possible. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 460		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake;	0 470		

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0 470	Continued From page 3 (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a written staffing plan that included an evaluation completed by the clinical nurse supervisor (CNS) (as indicated in Minnesota Administrative Rule 4659.0180) at least twice a year. The licensee further failed to post the staffing schedule in a central location. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: The licensee held an assisted living license and was licensed for a capacity of four residents and had a current census of three residents. On June 10, 2024, at 11:10 a.m., the surveyor observed the common areas of the facility and noted the lack of a 24-hour staffing schedule.	0 470		

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0 470	Continued From page 4 On June 10, 2024, at 11:15 a.m., owner/housing manager (O/HM)-A stated they had not developed a written staffing plan and had not posted a staffing schedule because the residents know all the staff and can see who is working. The licensee's Staffing policy dated July 23, 2021, indicated the clinical nurse supervisor will prepare and implement a 24-hour daily staffing plan that ensures adequate staffing to meet residents' needs at all times, including reasonably foreseeable needs. The schedule is posted at the beginning of the shift in a central location in each building, if applicable, accessible to staff, residents, volunteers, and the public. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 480		

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0 480	Continued From page 5 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 June 11, 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		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by:	0 550		

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0 550	Continued From page 6 Based on observation, interview, and record review, the licensee failed to post the required information related to the grievance procedure and contact information for the Office of Ombudsman for Long-Term Care and Mental Health and Developmental Disabilities. This had the potential to affect all the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The licensee lacked a posting of the grievance procedure, including the name, telephone number and e-mail contact information for the individuals who were responsible for handling resident grievances. On June 10, 2024, at 11:10 a.m., the surveyor observed the entry area and common areas within the facility and noted there was no required posting of the grievance procedure. On June 10, 2024, at 11:15 a.m., owner/housing manager (O/HM)-A stated he knew the complaint form should be posted, but just had not done it. The licensee's undated document Items to be Posted in Assisted Living Residences indicated for posting in public area: grievance procedure with phone numbers/contact information for individual responsible for handling resident	0 550		

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0 550	Continued From page 7 complaints, state and any regional Office of Ombudsman for Long-Term-Care, Office of Ombudsman for Mental Health and Developmental Disabilities, and Minnesota Adult Abuse Reporting Center. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing 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.	0 680		

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0 680	Continued From page 8 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all visitors, employees, 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On June 10, 2024, at 1:20 p.m., owner/housing manager (O/HM)-A stated the emergency preparedness plan had not been fully developed and was missing most of the required information. O/HM further stated the emergency plan was not available to all as the binders were locked in the office and some of it was in the computer. The licensee's Emergency Preparedness policy dated July 23, 2021, indicated [the facility] will have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. No further information provided. TIME PERIOD FOR CORRECTION:	0 680		

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0 680	Continued From page 9 Twenty-One (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that functioned and are interconnected so that the actuation of one alarm causes all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents.	0 780		

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0 780	Continued From page 10 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a facility tour on June 11, 2024, at approximately 1:25 p.m. with the owner/house manager (O/HM)-A. the survey staff tested the smoke alarms throughout the home. It was observed that there was one smoke alarm outside the lower level bedrooms that was missing. Also, when the smoke alarms were push button tested only the alarm tested operated. All the smoke alarms in the residence where not interconnected. These deficient conditions were visually verified by O/HM-A accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
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	0 790		

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0 790	Continued From page 11 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. This deficient condition 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On a facility tour on June 11, 2024, at approximately 1:50 p.m., the surveyor toured the facility with the licensed assisted living director (O/HM)-A. It was observed that the portable fire extinguishers throughout the facility lacked records to show the required annual certification on the portable fire extinguishers. The fire extinguishers did not have a certification tag. The manufactured date on the fire extinguisher is 2022. Documentation is required to demonstrate fire extinguishers have been inspected by facility personnel monthly, and annually replaced with a	0 790		

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ACE HOMES INC	3425 77TH AVENUE NORTH BROOKLYN PARK, MN 55443

(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
0 790	Continued From page 12 new extinguisher or serviced annually by a certified technician. During interview, survey staff explained to O/HM-A that the portable fire extinguishers must be provided annual certification tags and monthly visual inspection or "quick checks" of each extinguisher by their employees to ensure all portable extinguishers are readily available, fully charged, and operable at their designated location with no obvious physical damage or condition to the extinguisher that would prevent their operation when needed. O/HM-A verified the findings and stated that they understood the requirements. 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. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors.	0 800		

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0 800	Continued From page 13 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 a facility tour on June 11, 2024, at approximately 1:30 p.m. with the (O/HM)-A it was observed that electrical receptacles and switches in the garage and by the furnace in the lower level were missing covers. The surveyor explained to the O/HM-A that all electrical boxes shall have a cover installed and kept in place at all times. It was observed in bedroom B the electrical receptacle box was pulled away from the wall. The surveyor explained to the O/HM-A, that all electrical boxes shall be secured and covered at all times. These deficient conditions were visually verified by O/HM-A accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment	0 810		

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0 810	Continued From page 14 (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide required training and drills for residents. This had the potential to directly affect all residents, staff, and	0 810		

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0 810	Continued From page 15 visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on June 11, 2024, at approximately 1:45 p.m. with the owner/house manager (O/HM)-A on the fire safety and evacuation plan and fire safety and evacuation training and drills for the facility. Record review indicated the licensee failed to provide fire safety and evacuation training to employees upon hire and at least twice per year thereafter. Record review indicated the licensee failed to offer fire safety and evacuation training to residents at least once per year. Record review indicated the licensee failed to provide evacuation drills twice per year per shift with at least one evacuation drill per month. During the tour, the surveyor noted there were no evacuation maps posted in the facility. Fire safety and evacuation plans shall be readily available at all times within the facility. These deficient conditions were verified by O/HM-A during the review and while accompanying on the tour.	0 810		

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0 810	Continued From page 16 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 820 SS=D	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 provide facilities that were not a distinct hazard to life. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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 Findings include:	0 820		

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0 820	Continued From page 17 On a facility tour on June 11, 2024, at approximately 1:30 p.m. with the owner/house manager (O/HM)-A it was observed the window in bedroom B was too far off the floor. The measurement was 52". The surveyor explained to the O/HM-A, that a permanent step or bed shall be installed in front of the window. Per SFMD Policy, escape windows with openings up to 52 inches off of the floor may meet the height requirement for existing buildings by securing a step, platform or bed to the wall directly underneath the window. This step, platform or bed shall be no more than 44 inches below the opening and must be strong enough to support the weight of the person. The minimum acceptable width shall be the same as the window opening. The minimum acceptable depth away from the wall shall be 18 inches. The deficient condition was visually verified by O/HM-A accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 820		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter;	01470		

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01470	Continued From page 18 (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 topics: (1) an explanation of age-related hearing loss	01470		

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01470	Continued From page 19 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 ensure orientation to assisted living facility licensing requirements and regulations included all required content for one of one employee (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) 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: ULP-B was hired on May 1, 2020, to provide direct care services to residents at the assisted living facility. On June 11, 2024, at 9:05 a.m., the surveyor observed ULP-B administer medications. ULP-B's employee records lacked the following	01470		

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01470	Continued From page 20 required orientation content: - overview of assisted living statutes -the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights -a review of the types of assisted living services the employee will be providing and the facility's category of licensure On June 12, 2024, at 10:25 a.m., owner/housing manager (O/HM)-A stated they use Educare (online training program) and not all the correct classes were assigned to staff. O/HM-A further stated the same would be true for all staff. The licensee's Staff Orientation and Education policy dated July 23, 2021, indicated orientation topics will include: -overview of Minnesota assisted living statute 144G and Minnesota rules chapter 4659 -the assisted living bill of rights and the employee's responsibilities to ensure the exercise and protection of those rights -the types of assisted living services the employee will be providing based on the Uniform Checklist Disclosure of Services and the organization's category of licensure. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another	01500		

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01500	Continued From page 21 source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training 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 topics: (1) an explanation of age-related hearing loss	01500		

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01500	Continued From page 22 and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the 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 ensure an employee received at least eight hours of annual training for each 12 months of employment for one of one employee (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) 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: ULP-B had a hire date of May 1, 2020. On June 11, 2024, at 9:05 a.m., the surveyor observed ULP-B administer medications. ULP-B's record lacked evidence of annual training to include: - effective approaches to use to problem solve	01500		

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01500	Continued From page 23 when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders - review of provider's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures - principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff On June 12, 2024, at 10:25 a.m., owner/housing manager (O/HM)-A stated they use Educare (online training) and did not have all the correct classes assigned for staff's annual training and it would be the same for all staff. O/HM-A further stated he has now assigned all the correct classes for all staff. The licensee's Staff Orientation and Education policy dated July 23, 2021, indicated all staff providing assisted living services will complete at least eight (8) hours of education for every twelve (12) months of employment. Education topics will include: -effective approaches to use to problem solve when working with a resident's challenging behaviors and how to communicate with residents who have dementia, Alzheimer's Disease or related disorders -review of organization's policies and procedures related to provision of assisted living services and how to implement them - the principles of person-centered planning and service delivery and how they apply to direct support services provided by staff No further information was provided.	01500		

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01500	Continued From page 24 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
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 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 (RN) completed ongoing reassessment and monitoring using the uniform assessment tool for one of one resident (R1).	01620		

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01620	Continued From page 25 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: R1 was admitted and began receiving services on October 25, 2023. R1's most recent assessment dated April 22, 2024, did not include all the required elements on the uniform assessment tool. On June 12, 2024, at 11:40 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated he has been using the same assessment tool for all the resident assessments and thought it met all the requirements. LALD/CNS-C further stated they have switched to an electronic medical record system which will meet all the uniform assessment tool requirements when completing assessments. The licensee's Comprehensive Nursing Assessment policy dated February 17, 2022, indicated the registered nurse (RN) will conduct a comprehensive assessment for all residents admitted to [the facility] to determine the services required and to develop an individualized care plan for staff to implement. The assessment addresses the resident's physical, mental, and cognitive needs. The Minnesota Administrative Rule 4659.0150	01620		

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01620	Continued From page 26 dated August 11, 2021, indicated each facility must develop a uniform assessment tool to include all the required elements. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01700 SS=F	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications.	01700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35375	A. BUILDING: _____ B. WING _____	06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACE HOMES INC	3425 77TH AVENUE NORTH BROOKLYN PARK, MN 55443

(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
01700	Continued From page 27 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted an assessment to determine what medication management services would be provided and how the medication services would be provided for one of one resident (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) 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: R1 admitted to the facility and began receiving services on October 25, 2023. R1's service plan dated October 25, 2023, indicated R1 received services to include assistance with medications. R1's record lacked a medication assessment to meet all requirements. On June 12, 2024, at 10:40 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated he was using old forms for the medication assessment and had recently switched to RTasks (electronic medical record) so the medication assessments will now meet the requirements. The licensee's Assessment of Medications policy	01700		

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01700	Continued From page 28 dated July 23, 2021, indicated prior to providing medication management services, [the facility] will provide an assessment by a registered nurse (RN) to determine what medication management services will be provided and how they will be implemented. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered	01730		

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01730	Continued From page 29 nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and maintain a current individualized medication management record to include all required content for one of one resident (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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On June 11, 2024, at 9:05 a.m., the surveyor observed unlicensed personnel (ULP)-B administer medications to R1.	01730		

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01730	Continued From page 30 R1's medication management plan lacked the following: - procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services On June 12, 2024, at 10:40 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated he was using old forms that did not meet the requirement but had recently changed to an electronic medical record that will meet the requirements. The licensee's Assessment of Medications policy dated July 23, 2021, indicated based on the results of the medication assessment, the RN will document an individualized medication management plan, including the following elements: procedures for notifying the registered nurse or licensed health professional regarding problems arising with medication management services. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01760 SS=F	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	01760		

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01760	Continued From page 31 administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure as needed (PRN) medications had documentation of effectiveness after administration for two of two residents (R1, 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 the residents). The findings include: R1 was admitted for services on October 25, 2023. R1's PRN Medication Record for May 2024, indicated R1 received PRN clonazepam 0.5mg 7 out of 31 days. R1's PRN Medication Record for June 2024, indicated R1 received PRN clonazepam 0.5mg 7 out of 11 days. R1's PRN medication record lacked documentation of the effectiveness of the PRNs	01760		

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01760	Continued From page 32 given. R3 was admitted for services on January 2, 2020. R3's PRN Medication Record for May 2024, indicated R3 received PRN hydroxyzine hydrochloride 50mg 4 out of 31 days and PRN Seroquel 50mg 4 out of 31 days. R3's PRN Medication Record for June 2024, indicated R3 received PRN hydroxyzine hydrochloride 50mg 6 out of 10 days and PRN Seroquel 50mg 6 out of 10 days. R3's PRN medication record lacked documentation of the effectiveness of the PRNs given. On June 12, 2024, at 10:40 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated he expected staff to complete a follow up on all PRN medications given and knows PRN effectiveness has not been documented. LALD/CNS further stated he or the other registered nurse will make sure MARs are audited weekly. The licensee's Medication Documentation policy dated July 23, 2021, indicated for PRN medications, documentation will include, when appropriate, the reason for the medication and follow-up to determine effectiveness. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		

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01910	Continued From page 33	01910		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include the medication strength, prescription number, quantity, date of disposition, and names of staff and other individuals involved in the disposition. 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	01910		

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01910	Continued From page 34 or has the potential to affect a large portion or all the residents). The findings include: R2 discharged from licensee on June 23, 2023. R2's discharge summary dated June 23, 2023, indicated R2 received medication management services. R2's record lacked evidence of documentation of R2's disposition of medications to include prescription number if applicable, quantity, to whom the medications were given, and the names of the staff and other individuals involved in the disposition. On June 10, 2024, at 12:10 p.m., owner/housing manager (O/HM)-A stated they do have the correct form to fill out which has all the required information, but did not use that form for this discharged resident, although they usually do. The licensee's Disposition and Disposal of Medications policy dated July 23, 2021, indicated upon disposition, [the facility] will document the following information in the clinical record: -name, strength, and prescription number of medication, as applicable -quantity -method of disposition or to whom the medications were given -date of disposition -name/signature of staff or other individuals involved in disposition -if applicable, to whom the medications were given No further information was provided.	01910		

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	35375	A. BUILDING: _____ B. WING _____	06/12/2024

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01910	Continued From page 35 TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
02320 SS=F	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. 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 one employee (unlicensed personnel/ULP-B) observed administering medications to two of two residents (R1, R4). 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: ULP-B had a hire date of May 1, 2020, under the comprehensive home care license and began providing assisted living services on August 1, 2021.	02320		

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	35375	A. BUILDING: _____ B. WING _____	06/12/2024

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02320	Continued From page 36 ULP-B's employee record contained documentation that ULP-B had completed a medication administration competency evaluation with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C on April 23, 2020. On June 11, 2024, at 9:05 a.m., the surveyor observed ULP-B administer medications to R1 and R4. ULP-B performed hand hygiene, gathered medication punch packs for R1, failed to check the punch pack labels against the electronic medication administration record (EMAR), punched the medications into a medication cup and gave them to R1. R1 took the medication cup of medication to his room. ULP-B then followed the same routine for R4's medication administration. When the medication administrations were complete, ULP-B documented in the EMAR. On June 11, 2024, at 9:10 a.m., ULP-B stated she was sure that R1 would take his medications and did not think she had to watch him. ULP-B further stated she was trained by LALD/CNS-C to compare the medication punch packs to the EMAR, checking the six rights of medication administration before administering the medications but does not do that. On June 12, 2024, at 10:40 a.m., LALD/CNS-C stated the medication training for unlicensed staff included orientation, online training through Educare, hands on training, return demonstration, and supervision. LALD/CNS-C further stated he has talked to staff already and will continue to do more training for medication administration and the way ULP-B administered medication for R1 and R4 was unacceptable.	02320		

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02320	Continued From page 37 The licensee's Medication Administration policy dated July 3, 2021, indicated residents of [the facility] are entitled to the safe administration of medications by qualified personnel according to a written medication management plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the required notice was posted at the main entryway of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all current residents in the assisted living facility, staff, and any visitors to the facility. This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the	03090		

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03090	Continued From page 38 residents). The findings include: On June 10, 2024, at 11:10 a.m., the surveyor observed the lack of an electronic monitoring notice to visitors with the correct verbiage posted. The sign posted indicated 'security warning: this property is monitored by electronic surveillance". On June 10, 2024, at 11:15 a.m., owner/housing manager (O/HM)-A stated he was not aware of the correct verbiage for the electronic monitoring sign. The licensee's Electronic Monitoring policy dated July 23, 2021, indicated [the facility] will post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

DEPARTMENT OF HEALTH

Type: Full
Date: *06/11/24*
Time: 11:32:29
Report: 1036241102

Food and Beverage Establishment Inspection Report

Location:
Ace Homes Inc
3425 77th Avenue North
Brooklyn Park, MN55443
Hennepin County, 27

Establishment Info:
ID #: 0039121
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6123230315
ID #:

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

The following orders were issued during this inspection.

2-200 Employee Health

2-201.11C ***** Priority 1 *****

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority.

NO EMPLOYEE ILLNESS LOG ON SITE. EXAMPLE MDH ILLNESS LOG PROVIDED AND EXPLAINED DURING INSPECTION.

Comply By: 06/11/24

3-500C Microbial Control: date marking

3-501.17B ***** Priority 2 *****

MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.

OBSERVED A BAG OF SHREDDED CHEESE IN THE FRIDGE WITH NO DATE LABEL. ISSUE CORRECTED ON SITE.

Comply By: 06/11/24

2-100 Supervision

2-102.12AMN

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

TO GET A CFPM YOU MUST TAKE EIGHT HOUR MANAGER CLASS, PASS TEST, AND MAIL APPLICATION IN TO MDH. INFO WAS EMAILED TO ESTABLISHMENT.

Comply By: 07/11/24

4-100 Equipment Construction Materials

4-101.17

MN Rule 4626.0490 Discontinue using wood and wood wicker as a food contact surface.

OBSERVED SOME DAMAGED WOODED SPOONS IN DRAWER. ITEMS DISCARDED ON SITE.

Corrected on Site

4-200 Equipment Design and Construction

4-204.112A

MN Rule 4626.0620A Provide a temperature measuring device located in the warmest part of mechanically refrigerated units and coolest part of hot food storage units that are capable of measuring air temperature or a simulated product temperature.

NO THERMOMETER IN WAS ABLE TO BE LOCATED IN KITCHEN FRIDGE AND FREEZER. PROVIDE AND MAINTAIN.

Comply By: 07/11/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

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

OBSERVED SOME FOOD CRUMBS/DEBRIS IN THE DRAWERS AND CABINETS. CLEAN AND MAINTAIN.

Comply By: 07/11/24

Surface and Equipment Sanitizers

UTENSIL SURFACE TEMP: = at 168 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/MILK
Temperature: 36 Degrees Fahrenheit - Location: KITCHEN FRIDGE
Violation Issued: No

Process/Item: Ambient Temp
Temperature: 2 Degrees Fahrenheit - Location: KITCHEN FREEZER
Violation Issued: No

Process/Item: Ambient Temp
Temperature: 5 Degrees Fahrenheit - Location: CHEST FREEZER
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	1	1	4

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. SURVEYOR WAS WENDY ROBARGE. INSPECTION CONDUCTED IN PRESENCE OF LIBAN MOHAMUD, THE PERSON IN CHARGE. ALL VIOLATIONS WERE DISCUSSED WITH THE PERSON IN CHARGE AND SURVEYOR DURING INSPECTION.

THIS FACILITY DOES NOT HAVE ALL COMMERCIAL GRADE ANSI EQUIPMENT. ALL FOOD MUST BE SERVED THE SAME DAY IT IS PREPARED, AND LEFTOVERS CAN NEVER BE SAVED.

FOOD SERVICE IS PROVIDED BY FACILITY STAFF.

FOOD SERVICE AREA FLOORS, WALLS, CEILINGS, COUNTERTOPS, AND FINISH MATERIALS MUST BE NON-ABSORBANT, SMOOTH, DURABLE, AND EASILY CLEANABLE. CEILINGS CANNOT HAVE POPCORN TEXTURE. CABINETS CANNOT HAVE HOLLOW BASES. EXPOSED WOOD IS NOT APPROVED FOR FOOD SERVICE AREAS. WOOD IS NOT AN APPROVED FOOD CONTACT SURFACE.

THESE TOPICS WERE DISCUSSED WITH THE PERSON IN CHARGE:
- EMPLOYEE ILLNESS EXCLUSION
- HAND WASHING PROCEDURE
- NO BARE HAND CONTACT WITH RTE FOOD
- THERMOMETER USE/CALIBRATION
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS
- DATE MARKING
- PROPER FOOD STORAGE
- ANSI 184 DISH WASHER

FOR CORRECT BY DATES REFER TO COMPLETE REPORT ISSUED BY HRD.

**IF ANY RESIDENT COMPLAINS OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE CUSTOMER. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.

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

I acknowledge receipt of the inspection report number 1036241102 of 06/11/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____ Signed:_____

LIBAN MOHAMUD
PERSON IN CHARGE

Jeff Johanson