Electronically Delivered

October 16, 2024

Licensee
Center Care Inc.
3601 Portland Avenue
Minneapolis, MN  55407

RE:  Project Number(s) SL35962015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 11, 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.

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

**STATE CORRECTION ORDERS**
The enclosed State Form documents the state correction orders. 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,

Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

JMD

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 35962 | A. BUILDING: _____ B. WING _____ | 09/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CENTER CARE INC | 3601 PORTLAND AVENUE MINNEAPOLIS, MN 55407 |

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| 0 000 | Initial Comments<br><br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.<br><br>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.<br><br>INITIAL COMMENTS:<br><br>SL35962015<br><br>On September 9, 2024, through September 11, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were three residents; all of whom recieved services under the Assisted Living license. | 0 000 | Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>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. | |
| 0 460 SS=F | 144G.41 Subdivision 1 Minimum requirements<br><br>(5) provide a means for residents to request | 0 460 | | |

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| 0 460 | Continued From page 1<br><br>assistance for health and safety needs 24 hours per day, seven days per week;<br>(6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract;<br>(7) permit residents access to food at any time;<br>(8) allow residents to choose the resident's visitors and times of visits;<br>(9) allow the resident the right to choose a roommate if sharing a unit;<br>(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;<br><br>This MN Requirement is not met as evidenced by:<br>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 had the potential to affect all residents.<br><br>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).<br><br>The findings include: | 0 460 | | |

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| 0 460 | Continued From page 2<br><br>On September 9, 2024, at 12:30 p.m. during the entrance conference, assisted living director in residency (ALDIR)-A stated the licensee did not have a call light or pendant system for the residents to summon staff.<br><br>On September 9, 2024, at 2:10 p.m. during the facility tour, the surveyor observed the facility was a two-story home with a main floor and basement. One resident's room was in the basement, while the other resident rooms were on the second floor. No pendants or call light system was observed during the facility tour.<br><br>On September 9, 2024, at 2:17 p.m. ALDIR-A stated the licensee did not provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 460 | | |
| 0 470 SS=F | 144G.41 Subdivision 1 Minimum requirements<br><br>(11) develop and implement a staffing plan for determining its staffing level that:<br>(i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility;<br>(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<br>(iii) ensures that the facility can respond promptly and effectively to individual resident emergencies | 0 470 | | |

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| 0 470 | Continued From page 3<br><br>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:<br>(i) awake;<br>(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;<br>(iii) capable of communicating with residents;<br>(iv) capable of providing or summoning the appropriate assistance; and<br>(v) capable of following directions;<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to develop and implement a written staffing plan that included an evaluation completed by a registered nurse at least twice a year. This had the potential to affect all residents, staff, and visitors.<br><br>This practice resulted in a level two violation (a violation that did not harm a licensee'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).<br><br>The findings include:<br><br>The licensee held an assisted living license and was licensed for a capacity of four residents with | 0 470 | | |

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| 0 470 | Continued From page 4<br>a current census of three residents.<br><br>During the entrance conference on September 9, 2024, at 12:30 p.m. a staffing plan was requested. Assisted living director in residency (ALDIR)-A stated the licensee failed to develop and implement a staffing plan for determining its staffing level that included an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility.<br><br>On June 3, 2024, at 1:11 p.m. ALDIR-A stated the licensee has a monthly schedule posted, but it was not documented that an evaluation was completed by a registered nurse at least twice a year.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 0 470 | | |
| 0 480 SS=F | 144G.41 Subd 1 (13) (i) (B) Minimum requirements<br><br>(13) offer to provide or make available at least the following services to residents:<br>(B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code.<br>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<br><br>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).<br>The findings include:<br>Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated September 9, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.<br>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<br><br>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.<br><br>This MN Requirement is not met as evidenced by: | 0 550 | | |

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| 0 550 | Continued From page 6<br><br>Based on observation, interview, and record review, the licensee failed to post in a conspicuous place information about the facility's grievance procedure with the required content. This had the potential to affect all the licensee's residents, staff, and visitors.<br><br>This practice resulted in a level two violation (a violation that did not harm a client'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).<br><br>The findings include:<br><br>On September 9, 2024, at 2:10 p.m., the surveyor toured the facility with assisted living director in residency (ALDIR)-A. The licensee posted on a bulletin board on the main floor common area, the facility's grievance procedure; however, the grievance procedure lacked e-mail contact information for the individuals who were responsible for handling resident grievances. In addition, there was no evidence of the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care.<br><br>On September 9, 2024, at 3:06 p.m. ALDIR-A stated the required posting for the grievance procedure lacked the content as listed above.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 0 550 | | |

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| 0 630 | Continued From page 7 | 0 630 | | |
| 0 630 SS=D | 144G.42 Subd. 6 (b) Compliance with requirements for reporting ma<br><br>(b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to develop an individual abuse prevention plan (IAPP) with the required content for one of one resident (R2).<br><br>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).<br><br>The findings include:<br><br>R2 was admitted on March 10, 2024, with diagnoses including hypertension and diabetes.<br><br>R2's 90-day assessment dated September 6, | 0 630 | | |

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| 0 630 | Continued From page 8<br><br>2024, indicated R2 was not at risk to be abused and did not include:<br>-the resident's risk of abusing other vulnerable adults; and<br>-statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults.<br><br>On September 10, 2024, at 10:27 a.m. assisted living director in residency (ALDIR)-A confirmed R2's IAPP did not address the above noted areas of risk or include statements of specific measures to be taken to minimize risks. ALDIR-A stated they were not aware of the required contents of the IAPP and would work with the clinical nurse supervisor to complete.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 630 | | |
| 0 660 SS=F | 144G.42 Subd. 9 Tuberculosis prevention and control<br><br>(a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. | 0 660 | | |

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| 0 660 | Continued From page 9<br><br>(b) The facility must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) including completion of a current facility risk assessment, and failed to complete health history and symptom screening, including completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for one of one employee (unlicensed personnel (ULP)-B).<br><br>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 of the residents).<br><br>The findings include:<br><br>Facility Risk Assessment<br>During the entrance conference on September 9, 2024, at 12:30 p.m., the surveyor requested the licensee's current facility TB risk assessment. Assisted living director in residency (ALDIR)-A stated the licensee did not have a TB facility risk assessment completed. ALDIR-A indicated not being aware this had to be completed.<br><br>ULP-B | 0 660 | | |

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| 0 660 | Continued From page 10<br><br>ULP-B was hired on January 27, 2024, to provide direct care and services to the licensee's residents.<br><br>ULP-B's employee record lacked a baseline screening for active TB (either a two-step tuberculin skin test (TST) or blood test) was completed and documented.<br><br>On September 9, 2024, at 3:46 p.m. ALDIR-A stated the licensee had not completed their TB facility risk assessment and ULP-B's employee file lacked a history and symptom screening and baseline screening for active TB.<br><br>The licensee's Tuberculosis Screening/Prevention policy dated August 1, 2021, indicated the director is responsible for conducting the formal TB risk assessment and update it annually. Employees receive baseline TB screening upon hire to test for infection with M. tuberculosis. Baseline screening includes an assessment for TB history and current TB symptoms.<br><br>The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include a facility TB risk assessment. The guidelines also indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record. | 0 660 | | |

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| 0 660 | Continued From page 11<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 660 | | |
| 0 680 SS=F | 144G.42 Subd. 10 Disaster planning and emergency preparedness<br><br>(a) The facility must meet the following requirements:<br>(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;<br>(2) post an emergency disaster plan prominently;<br>(3) provide building emergency exit diagrams to all residents;<br>(4) post emergency exit diagrams on each floor; and<br>(5) have a written policy and procedure regarding missing residents.<br>(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.<br>(c) The facility must meet any additional requirements adopted in rule.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to have a written | 0 680 | | |

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| 0 680 | Continued From page 12<br><br>emergency preparedness (EP) plan with all the required content and failed to post an emergency preparedness plan prominently. This had the potential to affect all residents receiving services under the assisted living license, staff, and visitors.<br><br>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 of the residents).<br><br>The findings include:<br><br>During the initial tour on September 9, 2024, at 12:30 p.m. the facility's layout included one building with bathroom, kitchen, living room, dining room located on the main level, three resident rooms, bathroom located on the upper level and one bedroom, living area and laundry room on the lower level. There was no evidence of signage posted or information regarding the licensee's emergency plan.<br><br>The licensee lacked a plan to include the following required content:<br>- a comprehensive program to include infectious diseases and pandemics;<br>- a description of the population served by the licensee;<br>- process for EP cooperation and collaboration with state and local EP officials/organizations;<br>- procedure for tracking staff and residents;<br>- subsistence needs for staff and residents during emergency situation; | 0 680 | | |

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| 0 680 | Continued From page 13<br>- development of policies/procedures to address:<br>- evacuation plan (not customized for the facility);<br>- fire (not customized for the facility);<br>- shelter in place;<br>- a tracking system used to document locations or residents and staff;<br>- the medical record documentation system to preserve resident information;<br>- emergency staff strategies including surge planning and use of volunteers;<br>- the facility's role in providing care and treatment at alternative sites;<br>- a communication plan that included:<br>- arrangement with other facilities;<br>- names and contact information for staff, resident physicians, other facilities, volunteers;<br>- contact information for federal, state, tribal, local EP staff, ombudsman;<br>- primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management agencies;<br>- a method of sharing information and medical documentation for residents<br>- a means to provide information regarding the facility's needs, and the ability to provide assistance to include information about their occupancy;<br>-a method of sharing information from the emergency plan with residents and their families;<br>- EP training and testing program;<br>- EP training program for staff (including documentation of training provided); and<br>- EP testing/annual testing requirements.<br><br>On September 10, 2024, at 11:55 a.m. assisted living director in residency (ALDIR)-A stated the licensee had not fully developed and implemented the facility's emergency | 0 680 | | |

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| 0 680 | Continued From page 14<br><br>preparedness plan/program and did not have it posted prominently.<br><br>The licensee's Emergency Preparedness policy dated August 1, 2021, indicated the licensee 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. The licensee will review/update the emergency preparedness plan/program will be reviewed/updated at least annually. Documentation of education is maintained. A disaster drill is conducted at the residence at least annually and documented. The emergency disaster plan is prominently posted on each floor of the facility.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION:<br>Twenty-One (21) days | 0 680 | | |
| 0 730 SS=F | 144G.43 Subd. 3 Contents of resident record<br><br>Contents of a resident record include the following for each resident:<br>(1) identifying information, including the resident's name, date of birth, address, and telephone number;<br>(2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative;<br>(3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known;<br>(4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health | 0 730 | | |

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| 0 730 | Continued From page 15<br><br>records;<br>(5) the resident's advance directives, if any;<br>(6) copies of any health care directives, guardianships, powers of attorney, or conservatorships;<br>(7) the facility's current and previous assessments and service plans;<br>(8) all records of communications pertinent to the resident's services;<br>(9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional;<br>(10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional;<br>(11) documentation that services have been provided as identified in the service plan;<br>(12) documentation that the resident has received and reviewed the assisted living bill of rights;<br>(13) documentation of complaints received and any resolution;<br>(14) a discharge summary, including service termination notice and related documentation, when applicable; and<br>(15) other documentation required under this chapter and relevant to the resident's services or status.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure the licensee's one discharged resident record (R1) included a discharge summary with all the required content.<br><br>This practice resulted in a level two violation (a | 0 730 | | |

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| 0 730 | Continued From page 16<br><br>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).<br>The findings include:<br><br>R1 was admitted on February 15, 2024, and discharged on March 25, 2024, to a crisis center.<br><br>R1's discharge summary dated March 25, 2024, failed to include:<br>- a summary of the resident's stay that includes diagnoses, course of illnesses, allergies, treatments and therapies, and pertinent lab, radiology, and consultation results;<br>- a final summary of the resident's status from the latest assessment or review under Minnesota Statues, section 144G.70, if applicable, that includes the resident status, including baseline and current mental, behavioral, and functional status; and<br>- post discharge plan that is developed with the resident and, with the resident's consent, the resident's representatives, which will help the resident adjust to a new living environment. The post discharge plan must indicate where the resident plans to reside, any arrangements that have been made for the resident's follow-up care, and any post discharge medication and nonmedical services the resident will need.<br><br>On September 9, 2024, at 3:38 p.m. assisted living director in residency (ALDIR)-A stated R1's record lacked a discharge summary to include the required content as listed above.<br><br>The licensee's Discharge and Transfer of | 0 730 | | |

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| 0 730 | Continued From page 17<br><br>Residents policy dated August 2021, indicated at the time of discharge the community would provide the resident, and with the resident's consent, the resident's representatives, and case manager, with a written discharge summary that included:<br>-a summary of the resident's stay that included diagnoses, course of illnesses, allergies, treatments, and therapies, and pertinent lab, radiology, and consultation results;<br>-a final summary of the resident's status from the latest assessment or review under Minnesota Statues, section 144G.70, if applicable, which includes the resident status, including baseline and current mental, behavioral, and functional status;<br>-a reconciliation of all pre-discharge medications with the resident's post-discharge prescribed and over-the-counter medications; and<br>-a post-discharge plan that is developed with the resident and, with the resident's consent, the resident's representatives, which would help the resident adjust to a new living environment. The post-discharge plan must indicate where the resident plans to reside, any arrangements that have been made for the resident's follow-up care, and any post discharge medical and nonmedical services the resident would need.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 730 | | |
| 0 780 SS=F | 144G.45 Subd. 2 (a) (1) Fire protection and physical environment<br><br>(a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter | 0 780 | | |

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| 0 780 | Continued From page 18<br>7511, and:<br><br>(1) for dwellings or sleeping units, as defined in the State Fire Code:<br>(i) provide smoke alarms in each room used for sleeping purposes;<br>(ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms;<br>(iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics;<br>(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<br>(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;<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to provide interconnected smoke alarms throughout the facility. This had the potential to directly affect all residents, staff, and visitors.<br><br>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). | 0 780 | | |

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| 0 780 | Continued From page 19<br>The findings include:<br><br>During facility tour on September 11, 2024, from 10:05 a.m. through 10:35 a.m., with assisted living director in residency (ALDIR)-A, the surveyor observed that the smoke alarms throughout the facility were not interconnected so activation of one alarm activates all alarms throughout the facility.<br><br>All dwelling units required to have multiple smoke alarms are required to have interconnected alarms so activation of one alarm activates all alarms within the dwelling unit.<br><br>During the tour ALDIR-A tested the smoke alarms and verified the smoke alarms were not interconnected so activation of one alarm activates all alarms throughout the facility. ALDIR-A stated they understood the requirements.<br><br>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<br><br>(2) install and maintain portable fire extinguishers in accordance with the State Fire Code;<br><br>(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 | 0 790 | | |

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| 0 790 | Continued From page 20<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to properly install the portable fire extinguishers. This deficient condition had the potential to affect all staff, residents, and visitors.<br><br>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).<br><br>The findings include:<br><br>During facility tour on September 11, 2024, from 10:05 a.m. through 10:35 a.m., with assisted living director in residency (ALDIR)-A, the surveyor observed that the portable fire extinguisher on the main floor was located on a shelf in a closet. The extinguisher was not mounted in its location and there were no signs indicating its location.<br><br>Portable fire extinguishers shall be mounted in locations where they will have ready access and be immediately available for use. Portable fire extinguishers shall not be obstructed or obscured from view and means shall be provided to indicate the locations of extinguishers.<br><br>During the tour, ALDIR-A verified the findings and stated they understood the requirement. | 0 790 | | |

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| 0 790 | Continued From page 21<br>TIME PERIOD FOR CORRECTION: Seven (7) days. | 0 790 | | |
| 0 810 SS=F | 144G.45 Subd. 2 (b)-(f) Fire protection and physical environment<br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:<br>(1) location and number of resident sleeping rooms;<br>(2) employee actions to be taken in the event of a fire or similar emergency;<br>(3) fire protection procedures necessary for residents; and<br>(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.<br>(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.<br>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.<br>(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.<br>(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. | 0 810 | | |

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| 0 810 | Continued From page 22<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and failed to conduct the required training and evacuation drills. This had the potential to directly affect all residents, staff, and visitors.<br><br>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).<br><br>The findings include:<br><br>During facility tour on September 11, 2024, from 10:05 a.m. through 10:35 a.m., with assisted living director in residency (ALDIR)-A, the surveyor observed that the evacuation map posted in the basement did not have accurate rooms identified for the basement. There was a room being used as a bedroom that was labeled on the plan as an office. Survey staff explained that the map would need to be updated.<br><br>On September 11, 2024, at 10:35 a.m., ALDIR-A, provided documentation on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility.<br><br>FIRE SAFETY AND EVACUATION PLAN<br><br>The licensee's FSEP, titled "Fire Safety", dated | 0 810 | | |

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| 0 810 | Continued From page 23<br>August 1, 2021, failed to include the following:<br><br>The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation.<br><br>The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency.<br><br>During an interview on September 11, 2024, at 10:45 a.m., ALDIR-A stated they understood the area of the plan that needs to be updated and specific to this facility.<br><br>DRILLS<br><br>Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month as evident by not providing documentation of drills conducted or planned for a future date.<br><br>During an interview on September 11, 2024, at 10:45 a.m., ALDIR-A stated they were conducting drills quarterly. The surveyor explained the requirement for fire drills and showed ALDIR-A where the requirement was listed in their policy. ALDIR-A stated they understood the requirement for frequency of fire drills. | 0 810 | | |

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| 0 810 | Continued From page 24<br><br>TRAINING<br><br>Record review indicated the licensee failed to provide evacuation training based on the fire safety and evacuation plan to residents, at least once per year as evident by not providing documentation of training offered or training scheduled for a future date.<br><br>Record review indicated the licensee failed to provide evacuation training based on the fire safety and evacuation plan to employees, at hire and twice per year as evident by not providing documentation of training offered or training scheduled for a future date.<br><br>During an interview on September 11, 2024, at 10:45 a.m., ALDIR-A stated they were not conducting the training. The surveyor explained the requirement for training staff and residents and showed ALDIR-A where the requirement was listed in their policy. ALDIR-A stated they understood the requirement.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 0 810 | | |
| 01640 SS=E | 144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to<br><br>(a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on | 01640 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 35962 | A. BUILDING: _____ B. WING _____ | 09/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CENTER CARE INC | 3601 PORTLAND AVENUE MINNEAPOLIS, MN 55407 |

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|---|---|---|---|---|
| 01640 | Continued From page 25<br><br>resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities.<br>(c) The facility must implement and provide all services required by the current service plan.<br>(d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable.<br>(e) Staff providing services must be informed of the current written service plan.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure the current service plan included a signature or other authentication by the resident to document agreement on the services to be provided for two of two residents (R1, R2).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).<br>The findings include:<br><br>R1 and R2's Service Plans dated February 18, 2024, and March 12, 2024, lacked a signature or other authentication by the resident documenting agreement on the services to be provided. | 01640 | | |

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|---|---|---|---|---|
| 01640 | Continued From page 26<br><br>On September 10, 2024, at 8:16 a.m. unlicensed personnel (ULP)-C was observed to administer morning medications to R2.<br><br>On May 29, 2024, at 1:29 p.m. ALDIR-A stated R1 and R2's service plan had been developed on February 18, 2024, and March 12, 2024, and stated it lacked a signature by R1 and R2 as required.<br><br>The licensee's Service Plan policy dated August 1, 2021, indicated the initial service plan and any revisions are signed by a representative from licensee and the resident or resident's representative, indicating agreement with the services to be provided.<br><br>No further information was provided.<br><br>TIME PERIOD TO CORRECT- Twenty-one (21) days | 01640 | | |
| 01730 SS=D | 144G.71 Subd. 5 Individualized medication management plan<br><br>(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:<br>(1) a statement describing the medication management services that will be provided;<br>(2) a description of storage of medications based on the resident's needs and preferences, risk of | 01730 | | |

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|---|---|---|---|---|
| 01730 | Continued From page 27<br><br>diversion, and consistent with the manufacturer's directions;<br>(3) documentation of specific resident instructions relating to the administration of medications;<br>(4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis;<br>(5) identification of medication management tasks that may be delegated to unlicensed personnel;<br>(6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and<br>(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.<br>(b) The medication management record must be current and updated when there are any changes.<br>(c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure an individualized medication management plan included all required content for one of one resident (R2).<br><br>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 | 01730 | | |

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|---|---|---|---|---|
| 01730 | Continued From page 28<br><br>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).<br><br>The findings include:<br><br>R2 was admitted on March 10, 2024, with diagnoses that included hypertension and diabetes.<br><br>R2's prescriber orders dated September 5, 2024, included a pain reliever, a blood thinner, an antidepressant, two insulins, an oral hypoglycemic, and three antihypertensives.<br><br>R2's unsigned, Service Plan dated March 12, 2024, indicated R2 received services to include medication administration.<br><br>On September 10, 2024, at 8:16 a.m. unlicensed personnel (ULP)-C was observed to administer morning medications to R2.<br><br>R2's record failed to include an individualized medication management plan with all the required content:<br>- a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; and<br>- 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. | 01730 | | |

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|---|---|---|---|---|
| 01730 | Continued From page 29<br><br>On September 10, 2024, at 11:29 a.m. assisted living director in residency (ALDIR)-A stated the medication management plan lacked the required information as listed above.<br><br>The licensee's Service Plan for Medication Management policy dated August 1, 2021, indicated the medication management plan would include a description of the storage of medications based on the resident assessment and any resident-specific requirements related to documenting medication administration, verification that all medications are administered as prescribed and monitoring of medication use to prevent possible complications or adverse reactions.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01730 | | |
| 01890 SS=D | 144G.71 Subd. 20 Prescription drugs<br><br>A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure medications were maintained bearing the original prescription label and included the date opened of a time-sensitive drug for one of two residents (R2). | 01890 | | |

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|---|---|---|---|---|
| 01890 | Continued From page 30<br><br>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).<br><br>The findings include:<br><br>R2 was admitted on March 10, 2024, with diagnoses that included hypertension and diabetes.<br><br>R2's unsigned, Service Plan dated March 12, 2024, indicated R2 received services to include medication administration.<br><br>R2's provider's order dated September 5, 2024, included an order for liraglutide; inject 0.3 milliliters (mL) subcutaneously daily and insulin glargine; inject 35 units subcutaneously before bedtime.<br><br>On September 10, 2024, at 8:33 a.m. the medication cart was observed with unlicensed personnel (ULP)-C. The following was observed and verified missing an original prescription label and a date opened for a time sensitive drug:<br>-liraglutide insulin pen; and<br>-insulin glargine insulin pen<br><br>On September 10, 2024, at 8:42 a.m. assisted living director in residency (ALDIR)-A stated the insulin pens did not include a current original pharmacy label or an opened date. ALDIR-A stated the pharmacy did not provide a label for | 01890 | | |

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|---|---|---|---|---|
| 01890 | Continued From page 31<br><br>each individual insulin pen. There was a label on the box the pens came in; however, these were stored in the refrigerator.<br><br>On September 11, 2024, at 4:10 p.m. clinical nurse supervisor (CNS)-E stated the pharmacy did not provide a label for each individual insulin pen and a label was not kept with the opened insulin pens. CNS-E further stated insulin pens should be dated when opened.<br><br>The manufacturer's instructions for liraglutide insulin dated December 2020, directed to discard the pen 30 days after it had been opened, even if it still had medication left in it.<br><br>The manufacturer's instructions for insulin glargine insulin pens dated December 2019, directed to discard the pen 28 days after it had been opened, even if it still had insulin left in it.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01890 | | |
| 01910 SS=F | 144G.71 Subd. 22 Disposition of medications<br><br>(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.<br>(b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service | 01910 | | |

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|---|---|---|---|---|
| 01910 | Continued From page 32<br><br>contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances.<br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to complete the disposition of medications, 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 for the license's one discharged resident (R1).<br><br>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).<br><br>The findings include:<br><br>R1 began receiving services on February 15, 2024, with diagnoses including diabetes.<br><br>R1's discharge summary dated March 25, 2024, identified R1 received services which included medication administration. | 01910 | | |

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| 01910 | Continued From page 33<br><br>R1 was discharged from the licensee on March 25, 2024. R1's record lacked a completed documentation of a disposition of medications upon discharge that included a prescription number as applicable and to whom the medications were given for the following:<br>docycycline 100 milligrams (mg);<br>ferrous sulfate 325 mg;<br>lisinopril 5 mg;<br>Metformin 500 mg ER;<br>Methocarbamol 500 mg;<br>Pravastatin 40 mg;<br>Pregabalin 300 mg;<br>quetiapine fumarate 25 mg;<br>sertraline 100 mg;<br>sodium fluoride 1.1% Gel;<br>Vitamin D3 1,000 unit;<br>oxycodone and acetaminophen; and<br>ibuprofen 800 mg.<br><br>On September 9, 2024, at 3:38 p.m. assisted living director in residency (ALDIR)-A stated the licensee did not complete a disposition of medications upon R1's discharge to include the prescription number as applicable and to whom the medications were given. LALDIR-A further stated he did not know all that needed to be included on a medication disposition upon discharge.<br><br>The licensee's Disposition and Disposal of Medication policy dated August 1, 2021, indicated documentation of destruction included prescription number of medication and to whom the medications were given if as applicable.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01910 | | |

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| | | | | |

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

Type: Full
Date: *09/09/24*
Time: 13:05:00
Report: 1013241107

# Food and Beverage Establishment Inspection Report



**Location:**
Center Care Inc
3601 Portland Avenue
Minneapolis, MN55407
Hennepin County, 27

**Establishment Info:**
ID #: 0038380
Risk:
Announced Inspection: No

**License Categories:**

Expires on: / /

**Operator:**

Phone #: 6129863354
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.

**3-500B Microbial Control: hot and cold holding**

***3-501.16A2*** ***** Priority 1 *****

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

COLD TCS FOOD MEASURED ABOVE 41F IN THE KITCHEN REFRIGERATOR: EGGS 47F, MILK 47F, CHEESE 46F. COMPLY WITH RULE. DISCUSSED TEMP CONTROL AND STAFF ADJUSTED THE COOLER COLDER.

9/10/24
THE OPERATOR EMAILED PICTURES OF FOOD HOLDING AT 38F IN REFRIGERATOR.

*Corrected on Site*

**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.

UTENSILS AND WARE WERE AIR DRYING IN THE KITCHEN. PER STAFF THE WARE WAS WASHED WITH SOAP THEN AIR DRIED. COMPLY WITH RULE. DISCUSSED WARE WASHING PROCEDURES INCLUDING SANITIZING. REQUESTED STAFF REWASH WARE THEN SANITIZE IN THE DISH MACHINE.

*Comply By: 09/09/24*

**2-100 Supervision**

***2-102.11ABCQ*** ***** Priority 2 *****

MN Rule 4626.0030ABCQ The person in charge must be able to demonstrate their knowledge to the inspector of the following factors associated with employee health and the transmission of foodborne disease: symptoms of illness frequently associated with foodborne diseases; food worker illness reporting requirements; and medical conditions requiring exclusion of an employee from work or the restriction of

their work duties.

THE OPERATOR DID NOT KNOW SYMPTOMS ASSOCIATED WITH FOODBORNE ILLNESS OR HAVE A STAFF ILLNESS POLICY IN PLACE. COMPLY WITH RULE. MDH GUIDANCE DOCUMENTS WERE PROVIDED.

*Comply By: 09/09/24*

**4-300 Equipment Numbers and Capacities**

***4-302.13B*** ***** Priority 2 *****

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

HOT WATER SANITIZING DISH MACHINE IS USED IN THE FACILITY. NO TEST KIT MEETING THE ABOVE REQUIREMENT WAS AVAILABLE. COMPLY WITH RULE. A THERMAL TEST STRIP WAS PROVIDED TO TEST THE MACHINE.

*Comply By: 09/23/24*

**6-300 Physical Facility Numbers and Capacities**

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

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

NO PAPER TOWELS OR HAND DRYING DEVICE WAS AVAILABLE AT THE KITCHEN HAND WASHING SINK. STAFF IDENTIFIED THE SINK BASIN AS A HAND WASHING SINK. DISCUSSED HAND WASHING PROCEDURES AND PAPER TOWELS WERE STOCKED.

*Corrected on Site*

**2-100 Supervision**

***2-102.12AMN***

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

NO MN CFPM IS EMPLOYED AT THE FACILITY. 2 STAFF HAD CURRENT FOOD MANAGERS COURSE CERTIFICATES. COMPLY WITH RULE. THE MN CFPM INFORMATION WAS PROVIDED.

*Comply By: 12/02/24*

**6-300 Physical Facility Numbers and Capacities**

***6-301.14A***

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

NO HAND WASHING SIGN/POSTER WAS AVAILABLE AT THE KITCHEN HAND WASHING SINK. MDH HAND WASHING SIGNS WERE EMAILED.

*Comply By: 09/09/24*

---

**Surface and Equipment Sanitizers**

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

---

**Food and Equipment Temperatures**

Type: Full
Date: *09/09/24*
Time: 13:05:00
Report: 1013241107
Center Care Inc

# Food and Beverage Establishment Inspection Report

Process/Item: Milk
Temperature: 47 Degrees Fahrenheit - Location: Kitchen refrigerator
Violation Issued: Yes

Process/Item: Cheese
Temperature: 46 Degrees Fahrenheit - Location: Kitchen refrigerator
Violation Issued: Yes

Process/Item: Eggs
Temperature: 47 Degrees Fahrenheit - Location: Kitchen refrigerator
Violation Issued: Yes

Process/Item: Pizza
Temperature: 24 Degrees Fahrenheit - Location: Chest freezer
Violation Issued: No

| Total Orders In This Report | Priority 1 | Priority 2 | Priority 3 |
|---|---|---|---|
| | 2 | 3 | 2 |

The inspection was completed with the operator then reviewed with MDH Nurse Evaluator J. Panitzke.

The establishment has a residential kitchen and serves food that is prepared that day. The kitchen has wood cabinets, vinyl plank floor, tile walls, solid counter top, and a smooth painted ceiling.

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

A residential dish machine is used to wash ware. The dish machine is run on the sanitize/high temperature cycle.

Discussed hand washing, ware washing, staff illness policy, temperature control, final cook temperatures, cleaning, serving highly susceptible populations, glove use, food storage, 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 1013241107 of 09/09/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/__/_____

**Inspection report reviewed with person in charge and emailed.**

Signed:_____
Abdi Dahir
Operator

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