Electronically Delivered

September 17, 2024

Licensee
Totalcare Assisted Living
2365 Colorado Avenue North
Golden Valley, MN 55422

RE: Project Number(s) SL34951015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 16, 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,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 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
	34951	A. BUILDING: _____ B. WING _____	08/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOTALCARE ASSISTED LIVING	2365 COLORADO AVENUE NORTH GOLDEN VALLEY, MN 55422

(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: SL34951015-0 On August 13, 2024, through August 16, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 6 residents, all of whom were receiving services under the provider's Assisted Living Facility 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. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated August 13, 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		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and	0 510		

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0 510	Continued From page 2 nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. The deficient practice had the potential to affect all residents, employees, 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On August 13, 2024, at 1:15 p.m., the surveyor observed unlicensed personnel (ULP)-B provide medication and treatment administration to R2, which included blood glucose testing and insulin administration. ULP-B did not doff (remove) gloves after touching shared equipment that was not intended for R2.	0 510		

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0 510	Continued From page 3 During observation on August 13, 2024, at 1:15 p.m., ULP-B washed hands with soap and water at a sink in the kitchen and applied (donned) gloves to both hands. With the keys in the right, gloved hand, ULP-B unlocked the medication cabinet and obtained R2's medication storage container which held R2's blood glucose testing and insulin supplies. ULP-B obtained a lancet from a box and gave it to R2 to obtain a blood sample from his finger. ULP-B took two alcohol wipes and cleansed R2's left middle finger. ULP-B obtained R2's blood glucose level and proceeded to access the electronic medical record (EMR) on a computer.With gloved hands, ULP-B began typing on the keyboard. ULP-B then removed both gloves and threw them in a waste container. ULP-B returned to the sink and performed hand washing with soap and water. ULP-B donned a pair of gloves and returned to sit at the computer. With gloved hands, ULP-B again began typing on the keyboard, documenting R2's blood glucose level. ULP-B then reviewed the medication in the EMR and, with still gloved hands, obtained R2's insulin pens from R2's medication storage container. On August 13, 2024, at 1:25 p.m., ULP-B stated she viewed training videos on hand washing, glove use, and blood glucose testing when she was hired April 4, 2021. ULP-B stated she was competency tested by a registered nurse that currently worked for the licensee. On August 13, 2024, at 2:20 p.m., licensed assisted living director (LALD)-D stated all ULPs were required to watch training videos through Educare (an online training platform), observe the RN perform the delegated task and the RN would	0 510		

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0 510	Continued From page 4 ensure staff were performing the delegated tasks before they were able to work on their own. The licensee's Handwashing policy dated August 1, 2021, indicated handwashing would be performed before and after any gloving. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which	0 660		

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0 660	Continued From page 5 included completion of a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test for one of one employees (registered nurse (RN)-A). 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: The licensee's TB risk assessment dated July 25, 2024, indicated the licensee was a low risk setting for TB transmission. RN-A had a hire date of January 20, 2022. RN-A provided direct care to residents of the assisted living. RN-A's employee record lacked a completed TB screening form and documentation of a two-step TST or other evidence of baseline TB screening such as a blood test. During an interview on August 13, 2024, at 11:30 a.m., licensed assisted living director (LALD)-C stated he was not aware RN-A did not have evidence of TB screening or TB testing. During interview on August 13, 2024, RN-A stated she knew that she had a TB test done before she began working for the licensee but did not remember having one done when she began employment on January 20, 2022.	0 660		

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0 660	Continued From page 6 The Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, noted baseline screening for all health care workers (HCW) included a history and symptom screen, and testing for the presence of TB infection. The regulations noted a blood test should include the date of the test. The licensee's Employee Tuberculosis Prevention and Control policy was requested but not received. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
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	0 780		

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0 780	Continued From page 7 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 interconnected smoke alarms and failed to provide smoke alarms outside and in the immediate vicinity of sleeping rooms. 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 August 15, 2024, at 12:00 p.m., survey staff toured the facility with unlicensed personnel (ULP)-B and housing manager (HM)-D. During the tour, it was observed that a smoke alarm was not installed outside and in the immediate vicinity of sleeping rooms 6 and 5 on the lower level. It was also observed the installed smoke alarm outside and in the immediate vicinity of sleeping rooms on the main level was not interconnected upon testing, so the actuation of one alarm would cause all alarms to operate. During the interview on August 15, 2024, at 12:30	0 780		

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0 780	Continued From page 8 p.m., HM-D stated that the smoke alarm outside the sleeping rooms on the main level was a different type and not interconnected to the rest of the smoke alarms in the facility. HM-D also confirmed that a smoke alarm was not installed outside and in the immediate vicinity of sleeping rooms 6 and 5 on the lower level. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
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 physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. 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 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	0 800		

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0 800	Continued From page 9 of the residents). The findings include: On August 15, 2024, at 12:00 p.m., survey staff toured the facility with unlicensed personnel (ULP)-B and housing manager (HM)-D. During the facility tour, survey staff observed the following items: In resident sleeping room 3 on the main level, it was observed that there were cracked plaster and brown stains on the sheetrock ceiling with evidence of water damage from above. In resident sleeping room 5 on the lower level, it was observed that there was a large hole in the sheetrock ceiling. In the bathroom on the lower level, it was observed that there were cracked plaster and brown stains on the sheetrock ceiling with evidence of water damage. On August 15, 2024, at 12:30 p.m., during the facility tour, HM-D visually verified these deficient findings at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms;	0 810		

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0 810	Continued From page 10 (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide required employee training on fire safety and evacuation and failed to conduct required evacuation drills as required. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 810		

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0 810	Continued From page 11 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 August 15, 2024, at 1:00 p.m., housing manager (HM)-D provided documentation on the fire safety and evacuation plan (FSEP), fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. TRAINING Record review of the available documentation indicated employees did not receive training twice yearly after initial hire. In the provided FSEP, the facility policy required the staff training to be conducted at orientation and annually after. During the interview on August 15, 2024, at 1:30 p.m., HM-D stated the licensee provided annual training in March on the fire safety and evacuation plan to employees, but not twice per year after the initial hire, as required by statute. HM-D confirmed there was no further documented training for the staff on the fire safety and evacuation plan as required by statute. DRILLS Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month as required by statute. Provided documentation indicated that the drills were conducted on 6/6/24, 4/9/24, 3/2/24, 2/7/24, 12/7/23, 7/19/23, and 3/15/23. Provided	0 810		

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0 810	Continued From page 12 documentation indicated the facility failed to provide two drills for the night shift. During the interview on August 15, 2024, at 1:30 p.m., HM-D confirmed that the drills were not conducted between 12/7/23 and 7/19/23, and the facility provided only one drill for the night shift. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01350 SS=D	144G.60 Subd. 5 Temporary staff When a facility contracts with a temporary staffing agency, those individuals must meet the same requirements required by this section for personnel employed by the facility and shall be treated as if they are staff of the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure contracted staff met all requirements required for personnel employed by the facility for one of two employees (registered nurse (RN)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: RN-D began working as a contract employee on	01350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34951	A. BUILDING: _____ B. WING _____	08/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOTALCARE ASSISTED LIVING	2365 COLORADO AVENUE NORTH GOLDEN VALLEY, MN 55422

(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
01350	Continued From page 13 July 26, 2024 and provided assessment and supervisory services. RN-D's employee record lacked documentation of orientation to assisted living licensing requirements and regulations with the required content including: - Review of provider's policies and procedures; - Handling emergencies and using emergency services; - Reporting maltreatment of vulnerable adults or minors; - Home care/Assisted Living bill of rights; - Consumer advocacy services. During interview on August 13, 2024, at 11:45 a.m., RN-D stated he had never heard of the requirement to complete the licensee's orientation. RN-D further stated he would reach out to his employer to get the required orientation documentation. On August 13, 2024, at 11:55 a.m., licensed assisted living director (LALD)-C stated they did not have further orientation documentation for RN-D. The licensee's Staff Orientation and Education policy, dated August 1, 2021, indicated, all employees must complete the orientation to assisted living facility requirements before providing assisted living services to resident." The licensee's Volunteer and Contractor Records policy was requested but not received. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34951	A. BUILDING: _____ B. WING _____	08/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOTALCARE ASSISTED LIVING	2365 COLORADO AVENUE NORTH GOLDEN VALLEY, MN 55422

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Minnesota Department of Health
Environmental Health, FPLS
P.O Box 64975
Saint Paul
651-201-4500

Type: Full
Date: *08/13/24*
Time: 14:32:49
Report: 1018241116

Food and Beverage Establishment Inspection Report

Location:
Totalcare Assisted Living
2365 Colorado Avenue North
Golden Valley, MN55422
Hennepin County, 27

Establishment Info:
ID #: 0037866
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7632052253
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.

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) ***** Priority 1 *****

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

EGGS OBSERVED TO BE STORED ABOVE READY TO EAT FOODS IN THE REFRIGERATOR. DISCUSSED PROPER STORAGE WITH KITCHEN STAFF.

Comply By: 08/14/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.

KITCHEN CABINETS ARE MISSING THE ENTIRE BOTTOM PIECE ALL AROUND THE LENGTH OF THE CABINETS, MAKING VERY LARGE GAPS UNDERNEATH FOR FOOD AND DEBRIS TO GET TRAPPED. DISCUSSED WITH MANAGER TO HAVE THIS REPAIRED.

Comply By: 08/30/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.111ABD

MN Rule 4626.1565ABD Provide control of insects, rodents, and other pests by routinely inspecting incoming food and supply shipments; routinely inspecting the premises for evidence of pests; and eliminating harborage conditions.

NUMEROUS FRUIT FLIES OBSERVED IN THE KITCHEN AREA. DISCUSSED WITH KITCHEN STAFF TO CONTACT PEST CONTROL SERVICES.

Comply By: 08/14/24

Type: Full
Date: *08/13/24*
Time: 14:32:49
Report: 1018241116
Totalcare Assisted Living

Food and Beverage Establishment Inspection Report

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

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

ESTABLISHMENT IS A RESIDENTIAL HOME WITH RESIDENTIAL EQUIPMENT.

FLOORS, WALLS AND CEILINGS WERE OBSERVED TO BE IN GOOD CONDITION DURING THIS INSPECTION AND WILL BE MONITORED THROUGH THE YEARS.

ESTABLISHMENT DOES ALL SAME DAY SERVICE OF FOOD.

KITCHEN HAS A TWO BASIN SINK AND A DEDICATED HAND WASHING SINK.

DISHWASHER HAS SANITIZE FUNCTION AVAILABLE.

DISCUSSED EMPLOYEE ILLNESS AND ILLNESS REPORTING.

DISCUSSED PEST CONTROL.

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 1018241116 of 08/13/24.

Certified Food Protection Manager: PATRICIA O ONYAKWERE

Certification Number: FM111143 Expires: 05/05/25

Inspection report reviewed with person in charge and emailed.

Signed:_____
Establishment Representative

Signed:_____
Rebecca Prestwood
Sanitarian 3
6512013777
rebecca.prestwood@state.mn.us