Electronically Delivered

November 3, 2022

Administrator
Midwest Homes Inc
2445 10th Avenue South
Minneapolis, MN 55404

RE: Project Number(s) SL35007015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on October 19, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

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

The correction order documentation should include the following:

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

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

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should be addressed to:
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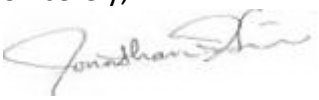
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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

Sincerely,



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35007	A. BUILDING: _____ B. WING _____	10/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST HOMES INC	2445 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

(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 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: SL35007015 On October 17 through October 19, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were three residents, all of whom received services under the provider's Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a staffing plan to determine staffing levels to meet the needs of all residents. This had the potential to affect all 12 residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a	0 470		

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0 470	Continued From page 2 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 converted to an assisted living license on August 1, 2021. On October 17, 2022, at 10:25 a.m., during the entrance conference, licensed assisted living director (LALD)-B stated they did not have a staffing plan documented that she knew of. LALD-B further stated she would ask administrator (A)-D. On October 18, 2022, at approximately 1:00 p.m., LALD-B verified the staffing plan was not developed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply:	0 480		

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0 480	Continued From page 3 (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 had the potential to affect all residents of the assisted living facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report, dated October 18, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant	0 580		

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0 580	Continued From page 4 to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in and maintain documentation of ongoing quality management activities relevant to the size and services provided by the assisted living provider. This had the potential to affect all three (3) residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 17, 2022, at 11:25 a.m., during the entrance conference, licensed assisted living director (LALD)-B stated she discussed quality management topics often with administrator (A)-D, registered nurse (RN)-A and other staff, but had not documented any of the meetings or a	0 580		

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0 580	Continued From page 5 current quality improvement project. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by:	0 680		

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0 680	Continued From page 6 Based on interview and record review, the licensee failed to develop a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all three (3) residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's "[Licensee] Emergency Preparedness Plan" updated March 2022, lacked individualized emergency procedures to include the following: - risk assessment; - consider duration of interruptions; - arrangements/contracts to re-establish utility services; - an assessment of at-risk population's needs; - categorize the various probable risks/hazards by likelihood of occurrence; - develop strategies for addressing community-based risks (evacuation plans, staffing/shortage, back-up plans) - a process for emergency preparedness cooperation with state and local EP officials/organizations; - a tracking system used to document locations of residents and staff; - the medical record documentation system to preserve resident information; - means of releasing and providing resident	0 680		

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0 680	Continued From page 7 information in the event of an evacuation; - means to providing information about occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee; - handling and use of volunteers; - plan to address food, water, medical supplies, and pharmaceutical supplies; - alternate sources of emergency and standby power systems to help maintain safe temperature, sanitation, emergency lighting, fire detection, sewage; - include a process for cooperating and collaboration with local tribal, regional, state, and federal EP to maintain integrated response; - EP training and testing program; - conducting exercises to test the EP at least twice per year; - participation in annual full-scale exercises; - analyze responses to and maintain documentation of all drills; - how the [licensee] would operate under an 1135 waiver; and - a written communication plan that included: - names and contact information for staff, resident physicians, other facilities; - a method of sharing information and medical documentation for residents; - contact information for Federal, State, tribal, regional, and local EP staff; - State Licensing and Certification Agency; and - other sources of assistance. On October 18, 2022, at 12:55 p.m., licensed assisted living director (LALD)-B stated they developed their own EP plan from a form received from a consulting service. LALD-B further stated they had developed the EP more thoroughly for their other licensee, but agreed	0 680		

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0 680	Continued From page 8 they needed to do more for this location. The licensee's undated Emergency Preparedness Plan - Appendix Z Compliance policy indicated, "[Licensee's] emergency preparedness plan will include all required elements of appendix Z. The plan will be in writing and reviewed annually. The plan is based on our assisted living-based and community-based risk assessments, utilizing an all-hazards approach." No further information provided TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to	0 780		

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0 780	Continued From page 9 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 interconnection and maintain smoke alarms in accordance with the State Fire Code as required by MN Statute 144G.45 Subd(a)(1). This has the potential to directly affect occupied residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 18, 2022, approximately from 1:20 p.m. to 2:35 p.m., survey staff toured the home with licensed assisted living director (LALD)-B and registered nurse (RN)-A. During the facility tour, survey staff observed the following: 1) The smoke alarms failed to sound all smoke alarms throughout the home as required for interconnection of all smoke alarms for proper notification. The finding was evident when the smoke alarms located in resident bedrooms, one smoke alarm on the main floor, and the combination smoke and carbon monoxide alarms located in hallways outside the vicinity of	0 780		

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0 780	Continued From page 10 bedrooms in the upper- and lower-level floors were tested, and each smoke alarm sounded local. LALD-B verified the finding as she agreed that they (smoke alarms) were supposed to be interconnected throughout the home. 2) The hardwired smoke alarms were removed from their housings as survey staff observed wires were exposed. LALD-B and RN-A confirmed the finding. On October 18, 2022, at approximately 3:15 p.m., LALD-B and RN-A acknowledged the findings during the exit interview. No Further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation, record review, and	0 790		

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0 790	Continued From page 11 interview, the licensee failed to maintain the portable fire extinguisher in the basement in accordance with the State Fire Code as required by MN Statute 144G.45 Subd(a)(2). 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 of the residents). The findings include: On October 18, 2022, approximately from 1:20 p.m. to 2:35 p.m., survey staff toured the home with licensed assisted living director (LALD)-B and registered nurse (RN)-A. During the facility tour, survey staff observed the portable fire extinguisher at the basement level was not serviced annually, as required. The date last serviced, as indicated on the tag, was December 2018. On October 18, 2022, at approximately 3:15 p.m., LALD-B and RN-A acknowledged the findings during the exit interview. LALD-B stated that she understood the extinguishers needed to be serviced annually and maintained and has already taken care of the other extinguisher in the home. No Further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 790		

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	35007	A. BUILDING: _____ B. WING _____	10/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST HOMES INC	2445 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

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0 800	Continued From page 12	0 800		
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 of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of occupied 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, 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). The findings include: On October 18, 2022, approximately from 1:20 p.m. to 2:35 p.m., survey staff toured the home with licensed assisted living director (LALD)-B and registered nurse (RN)-A. During the facility tour, survey staff observed the following: BATHROOMS	0 800		

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0 800	Continued From page 13 1) The upper-level bathroom had dark spots of mold growth on the sealant around the perimeter of the tub faucet and around the tub below the faucet. 2) The floor tile next to the toilet in the upper-level bathroom was broken and/or chipped and the toilet tank did not have the correct size cover. 3) The tub in the basement bathroom was clogged and had ponding of water with the drain stopper in an open position. 4)The perimeter of the tub in the basement bathroom had dark mold growth above and underneath the layers of sealant tape when survey staff lifted the tape at various locations around the tub to show the mold growth to LALD-B and RN-A. BEDROOM #1 (upper-level) 1) One of the windows in bedroom #1 was deteriorating beneath the sill and the arm hardware was detached and broken. 2) The lint screen inside the dryer located inside the closet of the bedroom was covered with a thick layer of lint. In addition, dust and lint located behind the dryer vent were observed by survey staff and needed to be cleaned out. 3) An extension cord was used inside the closet next to the clothes washer. The use of extension cords poses a potential electrical fire hazard from overloading the electrical circuits and must not be used. 4) Dead bug gnats were observed by survey staff on the windowsill. In addition, window screens were missing. LALD-B stated that the gnats came from the tree and were bad earlier this year. BEDROOM #3 (upper-level) 1) The egress casement window in resident room #3 (upper-level floor) was missing the handle. RN-A located the handle to open the window.	0 800		

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0 800	Continued From page 14 Survey staff explained the egress window must be in working order and be easily operable at all times for safe egress. 2) The air vent on the wall was missing a grille/cover. 3) Some areas of the wall were damaged and had exposed sheetrock located below the windows. BEDROOM #4 (Basement) The windowsill had dust and mold from excessive moisture or condensate on the surface. ELECTRICAL OUTLETS 1) An electrical outlet in bedroom #1 was missing a cover. 2) An electrical outlet on the main level by the shoe rack was damaged and only covered half of the outlet. On October 18, 2022, at approximately 3:15 p.m., LALD-B and RN-A acknowledged the above findings during the exit interview. No Further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency;	0 810		

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0 810	Continued From page 15 (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to provide all required content on the fire safety and evacuation plan, the required training on the fire safety and evacuation plan, and the minimum number of evacuation drills. This has the potential to directly affect the safety of occupied residents receiving care, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 810		

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0 810	Continued From page 16 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 18, 2022, at approximately 2:35 p.m., survey staff received and reviewed the home's fire safety and evacuation documentation, the evacuation drill, and the training documentation provided by licensed assisted living director (LALD)-B. FIRE SAFETY AND EVACUATION PLAN 1) The posted floor plan layout of the basement incorrectly indicated there were two bedrooms when there was one bedroom and one storage room. 2)The plan documentation lacked fire protection procedures for residents. 3) The plan documentation did not include the identification of unique or unusual resident needs for movement or evacuation under procedures for resident movement, evacuation, or relocation during a fire or similar emergency. 4) The home's fire policy, undated, lacked site-specific fire protection procedures for employees. The documentation had incorrect procedures in that the home was provided with a fire sprinkler system by indicating that sprinklers will be activated as necessary. In addition, the procedures also referred to magnetic holders for fire doors which the home did not have. DRILLS Documentation review indicated there was a lack of evacuation drills performed by employees. The record review indicated two fire and evacuation	0 810		

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0 810	Continued From page 17 drills performed and based on quarterly frequency rather than every other month. Drill records provided were April 4, 2022 (evening) and July 30, 2022 (morning). Survey staff explained to LALD-B and registered nurse (RN)-A that their policy (undated) had adopted the correct minimum required number of fire safety and evacuation drills twice per year per shift, with at least one evacuation drill every other month, but will need to carry out the drills and maintain records to show compliance with the requirement. TRAINING The licensee failed to meet the required employee training on the fire safety and evacuation plan to date. Survey staff explained to LALD-B and RN-A that employee training on fire safety and evacuation training is required at minimum upon hire and twice a year. On October 18, 2022, at approximately 3:15 p.m., LALD-B and RN-A acknowledged the findings during the exit interview. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 950 SS=C	144.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE	0 950		

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0 950	Continued From page 18 FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer the opportunity to identify a designated representative, on a separate form including statutory language, for one of one resident (R1). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 950		

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0 950	Continued From page 19 The findings include: R1 was admitted on December 14, 2021, and received services including assistance with meals, medication management, and blood glucose monitoring. R1's assisted living contract, signed September 13, 2022, lacked documentation indicating the R1 was given the opportunity to designate a representative for certain purposes, on a separate form with required statutory language. On October 17, 2022, at 3:07 p.m., licensed assisted living director (LALD)-B stated the Right to Designate a Representative for Certain Purposes form should be in resident chart. LALD-B verified the form was not in R1's chart, but stated it might have been kept electronically. On October 18, 2022, at 8:10 a.m., LALD-B stated she did not have a Right to Designate a Representative for Certain Purposes form completed for R1. LALD-B showed the surveyor the form they would use, but it did not include the required verbatim notice. The surveyor provided the statute with required verbatim text highlighted. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a	01440		

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01440	Continued From page 20 registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for one of two employees (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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:	01440		

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01440	Continued From page 21 ULP-C was hired on March 30, 2022, and provided direct care and assistance with treatment and medication administration for the licensee's residents. ULP-C's employee record included blood glucose testing education dated April 5, 2022, but lacked documentation of direct supervision of performing a blood glucose check within 30 days of providing the treatment. On October 17, 2022, at 3:46 pm., RN-A stated she completed the training and a competency evaluation of ULP-C for blood glucose testing but was not aware she needed to do a 30-day competency for the treatments. The licensee's undated Supervision of Staff - Delegated Services policy indicated, "Staff who provide delegated nursing or therapy tasks to residents at [licensee] will be supervised by an RN or appropriate licensed health professional where the services are being provided to verify that work is being performed competently and to identify problems and solutions related to the staff person's ability perform the tasks. Supervision will include observation of the staff administering the medication or treatment and the interaction with resident." The policy further indicated, "Direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for [licensee] and first performs the delegated tasks for residents and thereafter as needed based on performance." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One	01440		

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01440	Continued From page 22 (21) days	01440		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01940		

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01940	Continued From page 23 review, the licensee failed to ensure the registered nurse (RN) developed and implemented a treatment or therapy management plan to include all required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1's service plan dated December 14, 2021, indicated R1 received services including assistance with medication management, meals, bathing, grooming, and dressing. The service plan lacked information related to assistance with blood glucose monitoring for R1. R1's medication administration record (MAR) indicated R1 received daily assistance with blood glucose monitoring from September 6 through October 17, 2022. On October 18, 2022, at 9:00 a.m., the surveyor observed unlicensed personnel (ULP)-C assist R1 with a blood sugar check. R1's treatment or therapy management plan, dated December 14, 2021, lacked information related to blood glucose monitoring and lacked the following: -documentation of specific resident instructions relating to the treatments or therapy administration;	01940		

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01940	Continued From page 24 -procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and -any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On October 18, 2022, at 10:51 a.m., registered nurse (RN)-A stated she had not yet updated R1's Treatment and Therapy Management plan to include blood sugars. RN-A further stated she was not aware the treatments needed to be included in the residents' service plan. The licensee's undated Treatment & Therapy Management Plan policy indicated, "1. [Licensee] will develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: a. A statement of the type of services that will be provided b. Documentation of specific resident instructions relating to the treatments or therapy administration c. Identification of treatment or therapy tasks that will be delegated to unlicensed personnel d. Procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services e. Any resident-specific requirements relating to documentation of treatment and therapy received f. Verification that all treatment and therapy was administered as prescribed g. Monitoring of treatment or therapy to prevent	01940		

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01940	Continued From page 25 possible complications or adverse reactions. 2. The treatment or therapy management record must be current and updated when there are any changes." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01940		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to obtain prescriber orders for all treatments and therapies, including the frequency, duration and other information needed to administer the treatment or therapy for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35007	A. BUILDING: _____ B. WING _____	10/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST HOMES INC	2445 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

(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
01970	Continued From page 26 situation has occurred only occasionally). The findings include: R1's service plan dated December 14, 2021, indicated R1 received services including assistance with medication management, meals, bathing, grooming, and dressing. The service plan lacked information related to assistance with blood glucose monitoring for R1. R1's medication administration record (MAR) indicated R1 received daily assistance with blood glucose monitoring from September 6 through October 17, 2022. On October 18, 2022, at 9:00 a.m., the surveyor observed unlicensed personnel (ULP)-C assist R1 with a blood sugar check. R1's record lacked a signed prescriber order for blood glucose testing. On October 18, 2022, at 9:25 a.m., registered nurse (RN)-A confirmed a prescriber order for blood glucose testing was not present in R1's record. RN-A stated she remembered getting the order at the time it was entered into R1's MAR but was unable to provide the order. No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	01970		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors Subd. 8.Notice to visitors. (a) A facility must post a sign at each facility entrance accessible to	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35007	A. BUILDING: _____ B. WING _____	10/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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
03090	Continued From page 27 visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the required notice was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all current residents in the assisted living facility, staff, and any visitors to the facility. This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On October 17, 2022, at 10:35 a.m., the surveyor observed signs posted at both the front and back entrances to the facility with the words, "NOTICE This area is under 24-hour video surveillance". No signage was observed with the required verbiage regarding electronic monitoring. On October 17, 2022, at 11:30 a.m., licensed assisted living director (LALD)-B stated they did not have any other signage to indicate electronic	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35007	A. BUILDING: _____ B. WING _____	10/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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03090	Continued From page 28 monitoring. The licensee's undated Electronic Monitoring policy indicated, "signs are installed at each facility entrance accessible to visitors that state: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons or activities"." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

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

Type: Full
Date: *10/18/22*
Time: 13:11:42
Report: 1021221318

Food and Beverage Establishment Inspection Report

Location:
Midwest Homes Inc
2445 10th Avenue South
Minneapolis, MN55404
Hennepin County, 27

Establishment Info:
ID #: 0038108
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 6128651874
ID #:

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

The following orders were issued during this inspection.

2-200 Employee Health

2-201.11C ** Priority 1 **

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

NO EMPLOYEE ILLNESS LOG ON-SITE. DISCUSSED EMPLOYEE ILLNESS POLICY AND RECORDING WITH LALD. AN MDH EMPLOYEE ILLNESS LOG SENT WITH REPORT.

Comply By: 10/19/22

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.

RAW SHELL EGGS FOUND STORED ABOVE READY-TO-EAT ITEMS IN THE FRIGIDAIRE REFRIGERATOR. RAW SHELL EGGS WERE MOVED TO BOTTOM SHELF DURING INSPECTION TO PREVENT ANY CROSS-CONTAMINATION. CORRECTED ON-SITE. STORE RAW ANIMAL FOODS BELOW READY-TO-EAT ITEMS.

Comply By: 10/18/22

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.

ESTABLISHMENT IS NOT SANITIZING DISHES/UTENSILS AFTER WASHING. ALL FOOD CONTACT SURFACES OF EQUIPMENT, DISHES, UTENSILS, ETC. MUST BE FULLY SANITIZED AFTER WASHING AND RINSING WITH CLEAN WATER.

Comply By: 10/18/22

2-500 Responding to contamination events

2-501.11 ** Priority 2 **

MN Rule 4626.0123 Provide employees with procedures to follow for cleanup of vomit or fecal matter in the establishment. The procedures must minimize the spread of contamination to food and surfaces within the facility, and minimize the exposure of employees and consumers to contamination.

ESTABLISHMENT DOES NOT HAVE PROCEDURES IN PLACE FOR STAFF TO FOLLOW FOR THE CLEAN UP OF VOMIT AND/OR FECAL MATTER. FACT SHEET SENT WITH REPORT. TRAIN FOOD EMPLOYEES ON HOW TO PROPERLY CLEAN UP ACCIDENTS.

Comply By: 10/25/22

4-300 Equipment Numbers and Capacities

4-302.12B ** Priority 2 **

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

NO FOOD TEMPERATURE MEASURING DEVICE ON-SITE. PROVIDE A TEMPERATURE MEASURING DEVICE WITH A SMALL DIAMETER PROBE AND USE FREQUENTLY TO VERIFY FOOD TEMPERATURES.

Comply By: 10/25/22

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.

ESTABLISHMENT DOES NOT HAVE A MEASURING DEVICE ON-SITE THAT INDICATES THE FINAL UTENSIL SURFACE TEMPERATURE IN HIGH TEMPERATURE DISH MACHINE. PROVIDE. THERMOLABELS WERE LEFT ON-SITE. SEE COMMENTS.

Comply By: 10/25/22

4-300 Equipment Numbers and Capacities

4-302.14 ** Priority 2 **

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

NO TEST KIT ON-SITE TO MEASURE THE CONCENTRATION OF SANITIZER. DISCUSSED THE APPROVED FOOD CONTACT SURFACE SANITIZERS AND THEIR APPROPRIATE TEST KITS. PROVIDE AS DESCRIBED IN RULE ABOVE.

Comply By: 10/24/22

2-100 Supervision

2-102.12AMN

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

NO CERTIFIED FOOD PROTECTION MANAGER (CFPM) WAS EMPLOYED AT THIS ESTABLISHMENT. INFORMATION ON HOW TO OBTAIN A CFPM SENT WITH REPORT.

Comply By: 11/18/22

4-200 Equipment Design and Construction

4-204.112A

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

THE FRIGIDAIRE REFRIGERATOR IN THE KITCHEN DOES NOT HAVE A THERMOMETER. PROVIDE A THERMOMETER IN THE WARMEST PART OF THE FRIDGE AS DESCRIBED IN THE RULE ABOVE. ONE STAFF HAS A THERMOMETER IN THEIR CAR AND WILL PLACE IT IN THE FRIDGE.

Comply By: 10/19/22

4-300 Equipment Numbers and Capacities

4-303.11B

MN Rule 4626.0721B Provide chemical sanitizers to sanitize equipment and utensils during all hours of operation.

NO CHEMICAL SANITIZERS ON-SITE. DISCUSSED WITH LALD THE DIFFERENT APPROVED FOOD CONTACT SURFACE SANITIZERS. SANITIZER FACT SHEET SENT WITH REPORT. PROVIDE A CHEMICAL SANITIZER TO SANITIZE EQUIPMENT, UTENSILS AND FOOD CONTACT SURFACES.

Comply By: 10/18/22

4-500 Equipment Maintenance and Operation

4-501.11AB

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

THE DISH MACHINE IS CURRENTLY NOT WORKING. STAFF WILL GET DISH MACHINE REPAIRED OR REPLACED. IN THE MEANTIME, THEY WILL MANUALLY SANITIZE ALL OF THEIR DISHES AND UTENSILS WITH A CHEMICAL SANITIZER. SEE COMMENTS.

Comply By: 10/18/22

4-600 Cleaning Equipment and Utensils

4-601.11C

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

ACCUMULATION OF GREASE UNDER THE MICROWAVE (ABOVE THE STOVE). CLEAN AND MAINTAIN CLEAN.

Comply By: 10/21/22

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

HANDWASHING SINK IN THE KITCHEN AND IN THE BATHROOM IS MISSING A HANDWASHING SIGN/POSTER THAT REMINDS FOOD EMPLOYEES TO WASH HANDS

BEFORE RETURNING TO WORK. PROVIDE AS DESCRIBED IN RULE ABOVE.
Comply By: 10/20/22

6-300 Physical Facility Numbers and Capacities
6-304.11D
MN Rule 4626.1475D Discontinue operating the ventilation system with the filters removed.
TWO SMALL FILTERS ABOVE THE STOVE (UNDER THE MICROWAVE) WERE FOUND REMOVED. PLACE FILTERS BACK.
Comply By: 10/24/22

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: MILK - FRIGIDAIRE REFRIGERATOR
Violation Issued: No

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

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	3	4	7

ALL FINDINGS ON THIS REPORT WERE DISCUSSED WITH LICENSED ASSISTED LIVING DIRECTOR (LALD), REGINA STEPNEY AND HEALTH REGULATION DIVISION NURSE EVALUATOR, RENEE ANDERSON.

ONE COMPARTMENT OF THE TWO COMPARTMENT SINK HAS BEEN ASSIGNED AS A HANDWASHING SINK AND THE OTHER AS A PREPARATION SINK.

DISCUSSED WITH STAFF THE APPROVED TYPES OF SANITIZERS FOR FOOD CONTACT SURFACES. MAKING SURE THAT THE LABEL MENTIONS THAT IT CAN BE USED WITH NONPOROUS FOOD CONTACT SURFACES.

THE KITCHEN HAS RESIDENTIAL EQUIPMENT, WOOD CABINETS, LAMINATE FLOOR, AND UNABLE TO VERIFY IF THE BASE CABINETS WERE NOT
HOLLOW. PHYSICAL FACILITY ITEMS WILL BE MONITORED AT FUTURE INSPECTIONS.

CONTINUATION OF MN Rule 4626.0735AB
INSTRUCTED TO USE SINK AND LARGE CONTAINER TO SANITIZE ALL FOOD-CONTACT SURFACES OF DISHES AND UTENSILS UNTIL DISH MACHINE IS REPAIRED OR REPLACED.

CONTINUATION MN Rule 4626.0710B
THE THERMOLABELS WILL HELP THE ESTABLISHMENT VERIFY THAT THEIR DISH MACHINE IS PROVIDING A FINAL UTENSIL SURFACE TEMPERATURE OF 160F OR ABOVE.

Food and Beverage Establishment Inspection Report

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 1021221318 of 10/18/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____

REGINA STEPNEY
LALD

Signed:_____

Melissa Ramos
Environmental Health Specialist
Metro District Office
651-201-4495
Melissa.Ramos@state.mn.us