Electronically Delivered

September 19, 2024

Licensee
Beautiful Hearts LLC
3537 3rd Avenue South
Minneapolis, MN 55408

RE: Project Number(s) SL33535015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 14, 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,

Renee L. Anderson

Renee Anderson, Supervisor
State Evaluation Team
Email: renee.anderson@state.mn.us
Telephone: 651-201-5871 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
	33535	A. BUILDING: _____ B. WING _____	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEAUTIFUL HEARTS LLC	3537 3RD AVENUE SOUTH MINNEAPOLIS, MN 55408

(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: SL33535015-0 On August 12, 2024, through August 14, 2024, 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 four residents, all of whom received services under the provider's 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 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.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 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 12, 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		
0 495 SS=F	144G.41 Subd. 1 (14) Minimum Requirements (14) provide staff access to an on-call registered nurse 24 hours per day, seven days per week This MN Requirement is not met as evidenced	0 495		

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0 495	Continued From page 2 by: Based on observation and interview, the licensee failed to ensure that a registered nurse (RN) was available on-call 24 hours a day, seven days per week. This had the potential to affect all three residents and staff of the 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, 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 12, 2024, at 10:30 a.m., during the entrance conference, clinical nurse supervisor (CNS)-D stated she was the only nurse for the facility and also had a part- time job at the hospital on the mental health unit but was allowed to carry her phone with her and had always been available if the staff have called her. CNS-D further stated that the licensee was actively looking to hire another RN. On August 12, 2024, at 11:00 a.m., during the entrance conference, licensed assisted living director (LALD)-A stated that they currently only had one RN employed and were working on hiring another back up nurse. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 495		

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0 780	Continued From page 3	0 780		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that are interconnected so that the actuation of one alarm causes all alarms in the dwelling unit to actuate. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a	0 780		

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0 780	Continued From page 4 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: During facility tour on August 13, 2024, from 9:20 a.m. through 10:05 a.m., with licensed assisted living director (LALD)-A, the surveyor observed that the smoke alarms located throughout the facility were not interconnected so activation of one alarm activates all alarms throughout the facility. 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. During the tour the smoke alarms were tested by LALD-A. LALD-A verified the smoke alarms were not interconnected and stated that they understood the requirement. 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	0 800		

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0 800	Continued From page 5 residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. 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: During facility tour on August 13, 2024, from 9:20 a.m. through 10:05 a.m., with licensed assisted living director (LALD)-A, the surveyor made the following observations: The dryer vent was disconnected from the dryer and there was lint behind and in the area around the dryer. Dryer vents must be properly connected to discharge heat and lint to the exterior and not create a fire hazard. The outlet by the water heater was missing its cover plate. Outlets must be installed with proper cover plates that conceal electrical components to prevent accidental shock and not create a fire	0 800		

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0 800	Continued From page 6 hazard. The smoke detector on the ceiling at the bottom of the stairs to the basement was covered with drywall texture. Smoke detectors must be clean and free of obstructions so they function as intended. There was a loose handrail on one side of the stairs to the upper floor. Handrails are an integral part of the stair system and must be secured in place. The wooden front steps were slanted and had loose boards, creating a tripping hazard. The front porch had a roof supported by three posts. One post was loose and rotten at the bottom and one post had a gap at the top between the post and the beam. Structural components must be maintained and tight fitting to support the load they carry. There was a piece of siding missing on the North exterior wall and the wall sheathing was exposed to the weather. LALD-A visually verified these deficient findings at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
0 950 SS=C	144G.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	0 950		

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0 950	Continued From page 7 contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE 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 identify a designated representative or document that the resident declined to designate a representative 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	0 950		

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0 950	Continued From page 8 or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1's service plan, dated June 12, 2022, indicated R1 received services including assistance with activities of daily living (ADLs), housekeeping, and medication management. R1's contract, dated June 12, 2022, lacked documentation that R1 was given the opportunity to designate a representative and the required verbiage notifying R1 of their "right to designate a representative for certain purposes." During an interview on August 13, 2024, at 10:05 a.m., licensed assisted living director (LALD)-A stated R1's record lacked the required verbiage related to identifying a designated representative. LALD-A stated the required verbiage was missing from all residents' contracts because they were not aware the verbiage was required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a	0 970		

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0 970	Continued From page 9 lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident. 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 the potential to affect a large portion or all the residents). The findings include: R1's service plan, dated June 12, 2022, indicated R1 received services including assistance with activities of daily living (ADLs), housekeeping, and medication management. R1's contract dated June 12, 2022, included the following clauses that indicated the resident would waive the licensee's liability for health, safety, or personal property of a resident: "[Licensee] shall not be liable for any damage or injury to the resident, or any other person, or to any property, occurring on the premises, or any part thereof, or in common areas thereof, and the resident agrees to hold [Licensee] harmless from any claims or damages unless caused solely by negligence of [Licensee]."	0 970		

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0 970	Continued From page 10 On August 13, 2024, at 10:00 a.m., licensed assisted living director (LALD)-A stated the above language was included in all assisted living contracts. LALD-A stated they were not aware that they could not have the language in the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.	01620		

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01620	Continued From page 11 This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment, not to exceed 90 days from the previous assessment for two of two residents (R1 and R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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). The findings include: R1 was admitted July 7, 2018, and had diagnoses to include stroke, and type II diabetes. R1's record included documentation of completed comprehensive nursing assessment completed February 2, 2024. A subsequent (90-day) nursing assessment was completed May 12, 2024, ninety-eight days after the previous assessment. R3 was admitted September 9, 2022, and had diagnose to include bipolar (mental health disorder). R3's record included documentation of a comprehensive nursing assessment completed December 8, 2023. A subsequent (90-day) nursing assessment was completed April 2, 2024,	01620		

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01620	Continued From page 12 one hundred and sixteen days after the previous assessment. On August 13, 2024, at 10:40 a.m., licensed assisted living director (LALD)-A stated R1's and R3's assessments should have been completed 90 days from the last assessment, and the assessments were missed. LALD-A further stated that the licensee has updated the electronic medical records system to assure that assessments would be completed on time. The licensee's Assessment and Reassessment policy dated August 1, 2021, indicated ongoing assessments "cannot exceed 90 days from the last assessment". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (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 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.	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33535	A. BUILDING: _____ B. WING _____	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEAUTIFUL HEARTS LLC	3537 3RD AVENUE SOUTH MINNEAPOLIS, MN 55408

(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
01640	Continued From page 13 (c) The facility must implement and provide all services required by the current service plan. (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. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a current written service plan was revised to reflect the current services provided for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted July 7, 2018, and had diagnoses to include stroke, and type II diabetes. R1's service plan, dated June 12, 2022, indicated R1 received services including assistance with activities of daily living (ADLs), housekeeping, and medication management. On August 13, 2024, at 8:15 a.m., the surveyor observed unlicensed personnel (ULP)-C assist R1 with checking blood sugar.	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33535	A. BUILDING: _____ B. WING _____	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEAUTIFUL HEARTS LLC	3537 3RD AVENUE SOUTH MINNEAPOLIS, MN 55408

(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
01640	Continued From page 14 R1's record lacked an updated service plan to reflect the current services provided, including checking blood sugars daily. On August 13, 2024, at 11:05 a.m., licensed assisted living director (LALD)-A stated service plans were completed by clinical nurse supervisor (CNS)-D. CNS-D stated that they were not aware that treatments needed to be included on the service plan. The licensee's Service Plan policy dated August 1, 2021, indicated the service plan would include, "A description of the services that are to be provided based on the most recent assessment and resident preferences." The policy further indicated, " Services plans shall be revised, if needed, based on resident reassessments and monitoring," and "any revisions shall include a signature or other authentication by [licensee] and by the resident, or resident's representative." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		

Minnesota Department of Health
Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *08/12/24*
Time: 11:00:00
Report: 1039241242

Food and Beverage Establishment Inspection Report

Location:
Beautiful Hearts Llc
3537 3rd Avenue South
Minneapolis, MN55408
Hennepin County, 27

Establishment Info:
ID #: 0039367
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6123534335
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.

SHELL EGGS STORED ABOVE READY-TO-EAT FOODS IN REFRIGERATOR. PERSON-IN-CHARGE MOVED EGGS TO BOTTOM SHELF TO COMPLY WITH ABOVE. SEPARATION GUIDANCE DOCUMENT SENT WITH REPORT.

Corrected on Site

3-500C Microbial Control: date marking

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

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

OPENED CONTAINERS OF MILK AND TOMATO SAUCE IN REFRIGERATOR LACK A DATE MARK. COMPLY WITH ABOVE. CONSULT DATE MARKING FACT SHEET ON REFRIGERATOR FOR GUIDANCE.

Comply By: 08/12/24

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.

NO MIN/MAX WATERPROOF THERMOMETER OR COLOR-CHANGE THERMO TEST STRIPS

PRESENT FOR MEASURING DISHWASHER WATER TEMPERATURE PRESENT IN KITCHEN. COMPLY WITH ABOVE. GUIDANCE ON OPTIONS SENT WITH REPORT.

Comply By: 08/26/24

5-100 Water

5-103.12 ***** Priority 2 *****

MN Rule 4626.1020 Water under pressure must be provided to all fixtures, equipment, and nonfood equipment that are required to use water.

WATER NOT AVAILABLE AT SINK FAUCET, WATER ONLY BEING DIVERTED TO SPRAYER AT SINK. PERSON-IN-CHARGE ADJUSTED TO PROVIDE WATER AT FAUCET. MAINTAIN WATER AT FAUCET AT ALL TIMES.

Corrected on Site

6-300 Physical Facility Numbers and Capacities

6-301.11 ***** Priority 2 *****

MN Rule 4626.1440 Provide an adequate supply of hand soap at each handwashing sink or group of 2 adjacent handwashing sinks.

SOAP SUPPLY EMPTY AT SINK AT START OF INSPECTION. PERSON-IN-CHARGE ADDED SOAP SUPPLY AT SINK.

Corrected on Site

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 AT SINK AT START IF INSPECTION. PERSON-IN-CHARGE ADDED PAPER TOWELS DURING INSPECTION TO COMPLY WITH ABOVE.

Corrected on Site

3-300C Protection from Contamination: equipment/utensils, consumers

3-305.11A

MN Rule 4626.0300A Store all food in a clean, dry location; where it is not exposed to splash, dust or other contamination; and at least 6 inches above the floor.

BAGS OF RICE AND OTHER FOODS IN OPEN PACKAGES STORED ON FLOOR OF CLOSET. PERSON-IN-CHARGE MOVED FOODS ONTO SHELVING.

Corrected on Site

Food and Equipment Temperatures

Process/Item: MILK
Temperature: 37 Degrees Fahrenheit - Location: COLD HOLD IN REFRIGERATOR
Violation Issued: No

Type: Full
Date: *08/12/24*
Time: 11:00:00
Report: 1039241242
Beautiful Hearts Llc

Food and Beverage Establishment Inspection Report

Process/Item: FROZEN
Temperature: Degrees Fahrenheit - Location: FREEZER ON REFRIGERATOR
Violation Issued: No

Process/Item: FROZEN
Temperature: Degrees Fahrenheit - Location: CHEST FREEZER IN DINING AREA
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	1	5	1

The inspection was completed with the person in charge and reviewed with MDH nurse Angel Woehler.

The kitchen is of residential build and should serve food for same-day service only.

The kitchen has wood cabinets with hollow base, decorative tile floor, painted walls and ceiling, decorative tile countertops. Some wear is present on wood faces of lower cabinets. Some wear is present on wood trim of cabinets. Some pieces of trim on cabinets are missing. Establishment should repair or replace worn or missing surfaces to maintain smooth, non-absorbent, easily cleanable surfaces.

The kitchen refrigerator/freezer are of residential grade.

A 2-compartment sink is present in kitchen. 1 compartment is designated for handwashing only.

A residential dishwashing machine is present in the kitchen. Per thermos test strips (result shared by person-in-charge via email), the dish washing machine achieves a utensil surface temperature of at least 160 degrees F.

A supply of single-use gloves is present in kitchen. A thin-probe food thermometer is present in kitchen (probe should be cleaned/sanitized before and after each use). A supply of single-use sanitizing wipes for food contact surfaces is present in kitchen.

Discussed the following with the person-in-charge: minimum cook temps for animal proteins, food source, foodborne illness symptoms and exclusion of ill employees, avoiding bare hand contact with ready to eat foods, handwashing, sanitizing.

Type: Full
Date: *08/12/24*
Time: 11:00:00
Report: 1039241242
Beautiful Hearts Llc

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 1039241242 of 08/12/24.

Certified Food Protection Manager: Luqman Abdirahman Ibrahim

Certification Number: FM117294 Expires: 05/04/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
Najib Isse
person-in-charge

Signed: _____
Aron Goodner
Public Health Sanitarian I
Freeman Building
aron.goodner@state.mn.us