Electronically Delivered

March 13, 2024

Licensee
Alliance Wellness Homes LLC
5228 185th Street
Farmington, MN 55024

RE: Project Number(s) SL39789015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial survey on March 6, 2024, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

The Department of Health 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. The Department of Health documents state correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care 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 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
Per 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 residents/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 correction 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.

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.

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If you have any questions, please contact me.

Sincerely,

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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39789	A. BUILDING: _____ B. WING _____	03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLIANCE WELLNESS HOMES LLC	5228 185TH STREET FARMINGTON, MN 55024

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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: SL39789015-0 On March 4, 2024, through March 6, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were two residents; two receiving services under the provisional 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 March 4, 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		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults;	0 630		

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0 630	Continued From page 2 and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content 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 to the facility on January 6, 2024. R1's diagnoses included portal hypertension (a serious condition that affects the blood flow from the digestive organs to the liver), anxiety disorder, post-traumatic stress disorder (PTSD), attention/concentration deficit, alcohol/drug abuse, type two diabetes (when the body cannot effectively regulate blood sugar levels). R1's Service Plan dated January 8, 2024, included the services of medication management, assistance with dressing, bathing, and daily blood sugar checks.	0 630		

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0 630	Continued From page 3 R1's clinical notes dated February 20, 2024, indicated R1 became verbally abusive to staff and eloped from the facility. R1's IAPP dated January 6, 2024, identified R1 had vulnerabilities due to her dependency on staff for bathing, dressing, medications, and needed 24-hour supervision. R1's IAPP indicated she was not vulnerable to abuse by others; furthermore, R1's IAPP failed to identify specific measures to be taken to minimize the risk of abuse to her. R1's IAPP lacked an indication of her susceptibility to abuse others including other vulnerable adults and lacked interventions to mitigate her susceptibility to abuse others. Additionally, R1's IAPP indicated she was not at risk for elopement or wandering. Following R1's elopement incident, the licensee failed to update R1's IAPP to indicate her vulnerability to elopement from the facility and the measures in place to minimize her risk. On March 5, 2024, at 8:15 a.m. registered nurse (RN)-B stated R1 was a vulnerable adult and susceptible to abuse by others. She also indicated R1 had incidences of verbal aggression/abuse towards staff and another resident in the facility and had a recent incident of elopement. RN-B stated R1's IAPP needed to be updated to accurately reflect these vulnerabilities. The licensee's Vulnerable Adult policy dated April 11, 2023, indicated an IAPP would be established for each vulnerable adult for whom assisted living services were provided. The plan would include an assessment of the resident's susceptibility for abuse by others including other vulnerable adults. The plan would include the risk of abuse to others	0 630		

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0 630	Continued From page 4 including other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and	01060		

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01060	Continued From page 5 designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation for one of one resident (R2). 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: R2 was admitted to assisted living services on August 10, 2023. R2's Service Plan dated January 12, 2024, included the services of medication management, behavior management, bathing, dressing, and	01060		

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01060	Continued From page 6 grooming assistance, and housekeeping. R2's progress notes dated February 28, 2024, indicated "resident has been out of the facility to the hospital for schizoaffective disorder. Resident was taken to the hospital by EMS [emergency medical services] on February 14th and is admitted by committed per her case manager. Resident returned from the hospital on February 28, 2024, at 1:15 PM by a Cab driver." R2's After Visit Summary dated February 28, 2024, indicated R2 had been in the hospital from February 14, 2024, through February 28, 2024. R2's record lacked a written notice that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. In addition, R2's records lacked notification to the Office of Ombudsman for Long-Term Care the resident had been relocated and had not returned to the facility within four days. On March 4, 2024, at 12:00 p.m. licensed	01060		

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01060	Continued From page 7 assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she was not aware of the requirement for the relocation notice and notification of the Ombudsman. The licensee's Discharge and Transfer of Residents policy dated April 11, 2023, indicated in the event of an emergency relocation the facility would, as soon as possible, provide a written notice of emergency relocation. If a resident was relocated and not returned to the facility within four days, the Office of Ombudsman for Long-Term care would be notified. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days.	01060		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications;	01730		

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01730	Continued From page 8 (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individualized medication management plan included all required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect	01730		

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01730	Continued From page 9 a large portion or all of the residents). The findings include: R1's diagnoses included portal hypertension (a serious condition that affects the blood flow from the digestive organs to the liver), anxiety disorder, post-traumatic stress disorder (PTSD), attention/concentration deficit, alcohol/drug abuse, type two diabetes (when the body cannot effectively regulate blood sugar levels). R1's Service Plan dated January 8, 2024, indicated R1 received services to include medication management/administration. R1's medication orders dated January 11, 2024, included: - Trazodone 50 milligrams (mg), give one to two tablets (50-100 mg) as needed (PRN) at bedtime for sleep. R1's Medication Plan dated January 31, 2024, indicated the licensee was managing R1's medication services. R1's medication administration record (MAR) dated February 2024, indicated she received medications to include one blood thinner, one supplement, one monthly injection for migraines, one for depression, one for aggression, one for type two diabetes, one for acid reflux, one for cholesterol, one for diarrhea, one for nicotine dependence, one for nausea, and one for sleep. On March 5, 2024, at 7:19 a.m. unlicensed personnel (ULP)-C was observed to administer R1's scheduled morning medications. R1's record included a dosing range (one to two	01730		

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01730	Continued From page 10 tablets) for PRN trazodone and lacked direction for the ULP to identify what dose should be given, or the direction to call nursing for further instructions. On March 5, 2024, at 8:55 a.m. registered nurse (RN)-B stated she was not aware the RN needed to specify the need for instructions for the ULP to administer a medication with a dosing range. She stated the unlicensed staff may not consistently recognize the need for one or two tablets needed to manage symptoms for sleeplessness. The licensee's Medication Administration policy dated April 11, 2023, indicated all staff with responsibility for medication administration have access to information about the medication being administered, including instructions related to the medication and specific to the resident as appropriate. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure current written or electronically recorded prescriptions	01820		

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01820	Continued From page 11 were obtained for all medications the provider managed 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 started receiving services under the licensee's assisted living license on January 6, 2024. R1's service plan dated January 8, 2024, indicated she received services to include medication management and medication administration. On March 4, 2024, at approximately 2:00 p.m. the surveyor requested R1's signed physician orders. The licensee provided the surveyor with a signed order dated January 11, 2024, which included the following medications: -fluoxetine 20 milligrams (mg), one tablet in combination with fluoxetine 40 mg to equal 60 mg daily for depression -quetiapine 400 mg daily at bedtime for agitation -Trazodone 50 mg one to two tablets (50-100 mg) once daily at bedtime as needed for sleep Additionally, the licensee's facility standing orders were signed by the provider. On March 5, 2024, at 7:19 a.m. unlicensed staff was observed to set up and administer R1's eight scheduled morning medications, and one	01820		

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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
01820	Continued From page 12 additional as needed medication (ibuprofen) for the resident's complaint of a headache. R1's medication administration record (MAR) dated February 2024, indicated the following medications were administered without current signed physician orders: -aspirin 81 milligrams (mg), one tablet daily for blood thinning -certavitamin, one tablet daily as supplement -lisinopril 10 mg, one tablet daily for high blood pressure -omeprazole 20 mg, one capsule daily for acid reflux -simvastatin 40 mg, one tablet daily for high cholesterol -Metformin 500 mg, two tablets daily for type 2 diabetes (the body's inability to effectively manage blood sugar) -diclofenac gel, to right knee daily as needed for pain -ibuprofen 600 mg, one tablet daily as needed for headache -tizanidine 4 mg, one tablet daily as needed for muscle spasms -loperamide 2 mg, one tablet as needed for diarrhea R1's record lacked signed physician orders for the above listed medications. On March 5, 2024, at 8:55 a.m. registered nurse (RN)-B stated she could not find signed physician orders for the above listed medications. She stated the physician only returned the orders signed on January 11, 2024, and was unsure why the full list of medications (listed on the MAR) was not included in the signed orders. The licensee's Medication Orders policy dated	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39789	A. BUILDING: _____ B. WING _____	03/06/2024

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ALLIANCE WELLNESS HOMES LLC	5228 185TH STREET FARMINGTON, MN 55024

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01820	Continued From page 13 April 11, 2023, indicated the licensee would maintain a current written or electronically recorded prescription for all prescribed medications managed for the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
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 ensure up-to-date written or electronically recorded orders were maintained for one of two residents (R1) receiving treatments. 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).	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01970	Continued From page 14 The findings include: During the entrance conference on March 4, 2024, at 10:45 a.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A and registered nurse (RN)-B confirmed the licensee provided treatment and therapy services to the licensee's residents. R1's diagnoses included portal hypertension (a serious condition that affects the blood flow from the digestive organs to the liver), anxiety disorder, post traumatic stress disorder (PTSD), attention/concentration deficit, alcohol/drug abuse, type two diabetes (when the body cannot effectively regulate blood sugar levels). R1's Service Plan dated January 8, 2024, indicated R1 received daily blood sugar checks. On March 5, 2024, at 7:15 a.m. unlicensed personnel (ULP)-C was observed to check R1's blood sugar prior to breakfast. ULP-C stated R1's blood sugar was checked once daily prior to breakfast. R1's vital signs record dated February 1, 2024, through February 29, 2024, included daily blood sugar checks and results as completed and documented by the licensee's ULP. R1's Treatment Plan dated February 27, 2024, indicated R1 received daily blood sugar checks with instructions to notify nursing if blood sugar levels were below 70 or greater than 300. R1's record lacked an order for the treatment of daily blood sugar checks.	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01970	Continued From page 15 On March 4, 2024, at 3:00 p.m. RN-B stated R1's record lacked an order for daily blood sugar checks. The licensee's Treatment and Therapy Management policy dated April 11, 2023, indicated the RN or licensed health professional would obtain orders or prescriptions of all treatments or therapies. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		

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

Type: Full
Date: *03/04/24*
Time: 13:00:00
Report: 1043241047

Food and Beverage Establishment Inspection Report

Location:
Alliance Wellness Homes LLC
5228 185th Street
Farmington, MN55024
Dakota County, 19

Establishment Info:
ID #: 0042374
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/24

Operator:

Phone #:
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.

2-100 Supervision

2-102.12AMN

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

PER STAFF, CFPM OF CURRENT FACILITY IS ALSO THE CFPM AT ANOTHER FACILITY. ADVISED STAFF TO EMPLOY ONE FULL TIME EMPLOYEE AS THE CFPM, CFPM CANNOT BE USED ACROSS MULTIPLE LOCATIONS. PER STAFF, ANOTHER INDIVIDUAL IS IN THE PROCESS OF GETTING CERTIFIED.

Comply By: 09/04/24

Surface and Equipment Sanitizers

Hot Water: = at 160 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: BUTTER
Temperature: 40 Degrees Fahrenheit - Location: REACH-IN COOLER
Violation Issued: No

Process/Item: YOGURT
Temperature: 40 Degrees Fahrenheit - Location: REACH-IN COOLER
Violation Issued: No

Type: Full
Date: *03/04/24*
Time: 13:00:00
Report: 1043241047
Alliance Wellness Homes LLC

Food and Beverage Establishment Inspection Report

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

Discussed date marking, illness policy, sanitizer use, ware washing, temperature control, hand washing, cleaning, pest control, vomit/fecal procedures, test kits, food storage, and food handling procedures. CFPM fact sheet provided with report.

Inspection was completed with F. Farah and I. Shafie. D. Jacobson was the lead Health Regulation Division Nurse Evaluator on site completing the site survey.

**Foods cooked by the facility staff for clients should be fully cooked and prepared for same day service only and with leftovers discarded.

**This facility has a residential kitchen with residential equipment and wooden cabinetry. The kitchen finishes and surfaces are well maintained. Contact Health Regulation Division for plan review when facility undergoes remodeling.

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 1043241047 of 03/04/24.

Certified Food Protection Manager Ifrah Sheikh Shafie

Certification Number: FM63894 Expires: 10/05/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
Farhia Farah
PIC

Signed: Blia Lor
Blia Lor
Public Health Sanitarian I
651-355-0641
blia.lor@state.mn.us