Electronically Delivered

March 22, 2023

Licensee
The Sanctuary at West St Paul
1746 Oakdale Avenue
West Saint Paul, MN 55118

RE: Project Number(s) SL32587015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on February 16, 2023, 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.

LICENSING ORDERS
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 . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines and enforcement actions based on the level and scope of the violations; **however, no immediate fines are assessed for this evaluation of your facility**.

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.

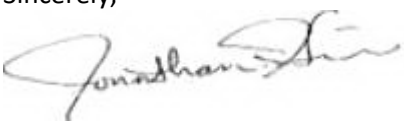
Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for 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

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,



Jonathan Hill, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jonathan.hill@state.mn.us
Telephone: 651-201-3993 Fax: 651-281-9796

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32587	A. BUILDING: _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SANCTUARY AT WEST ST PAUL	1746 OAKDALE AVENUE WEST SAINT PAUL, MN 55118

(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 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: SL32587015 On February 13, 2023, through February 16, 2023, 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 one hundred and thrirty-nine (139) residents, all of whom received services under the provider's Assisted Living with Dementia Care 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 with Dementia Care facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated January 15, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 780 SS=E	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:	0 780		

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0 780	Continued From page 2 (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 working smoke alarms inside resident apartment units 203 and 426. This has the potential to directly affect the resident in units 203 and 426. 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).	0 780		

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0 780	Continued From page 3 The findings include: On February 15, 2023, approximately from 11:30 a.m. to 3:20 p.m., survey staff toured the facility with the environmental services director (ESD)-F. During the tour, survey staff observed and the ESD-F verified the following: 1. Inside the one-bedroom resident apartment unit 203, the sleeping room smoke alarm failed to sound when activated by the ESD-F. 2. Inside the one-bedroom resident apartment unit 426, the hallway smoke alarm failed to sound at the activation of smoke alarm by the ESD-F. In addition, the batteries were missing from the smoke alarm when investigated by the ESD-F. On February 15, 2023, at approximately 4:15 p.m., during the exit interview, the licensed assisted living director-A and the ESD-F acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced	0 800		

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0 800	Continued From page 4 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 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 February 15, 2023, approximately from 11:30 a.m. to 3:20 p.m., survey staff toured the facility with the environmental services director (ESD)-F. During the tour, survey staff observed and the ESD-F verified the following: 1. The fire sprinkler riser on the 4th floor had accumulated excessive storage boxes that restricted ready access to the fire suppression system components. The system is required to be maintained and clear of obstructions to allow for the sprinkler system to be accessible. 2. The 4th laundry room fire-rated door next to stairway B failed to close tight and positively latch to maintain the fire rating of the room. The laundry/trash room fire-rated door located across from room 337 was missing a door self-closing hardware preventing the door from self-closing to maintain the fire rating of the trash room. 3. The exit door failed to open completely due to	0 800		

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0 800	Continued From page 5 ice build-up outside of the ground-level exit stairway B. Survey staff was only able to open the door halfway. As the walkways outside the door are the means of egress, the walkways are required to be maintained and be clear of obstruction the door must be able to open completely to allow for proper exit in the event of an emergency. 4. In resident apartment units 203, 207, 302 (living room), and 405, the carpet flooring was soiled. 5. In resident apartment units 212, 217, 405, 423, and 424, the air filters for the cooling and heating systems were dusty and/or dirty. 6. Three of the four water heaters had alarms on the displays. Two water heaters had an alarm displaying, "Lockout alarm" and one water heater had an alarm display that noted the unit was not functioning. 7. The hot water recirculation system piping had a small leak as there was water observed on the floor. The ESD-F explained the system has a pinhole leak and is under contractor for repair. 8. The ceiling inside the exercise room had water damage and had temporary ceiling covers. The ESD-F explained that the ceiling was damaged from a toilet overflow above and is currently under reconstruction and is already scheduled for repair. 9. In the memory care kitchenette area, a variety, and large jugs of cleaning chemicals (Drano, arsenal 24 (QT Plus) were stored under the kitchenette cabinet and were observed not secured from resident access. No staff was observed in the kitchenette area at the time. The DM-F verified the finding and relocated the chemicals into a secured room. 10. In memory care resident units 103 and 116, chemicals (Lysol and Pine-Sol) were observed under the kitchen cabinets.	0 800		

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0 800	Continued From page 6 On February 15, 2023, at approximately 4:15 p.m., during the exit interview, the LALD-A and the ESD-F acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) 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; (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.	0 810		

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0 810	Continued From page 7 (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 the minimum required employee training on fire safety and evacuation. This has the potential to directly affect the safety of all residents receiving services, 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 February 15, 2023, at approximately 3:30 p.m., survey staff received the facility fire safety and evacuation plan and related documentation for review from the licensed assisted living director (LALD)-A. At approximately 4:00 p.m., document review and interview with the LALD-A and the environment services director (ESD)-F indicated the licensee lacked a record of employee training specifically on the fire safety and evacuation plan consisting of twice a year (after new hire orientation). The document showed emergency training was provided	0 810		

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0 810	Continued From page 8 annually but lacked employee training on fire safety and fire safety and evacuation plan required twice per year. On February 15, 2023, at approximately 4:20 p.m., during the exit interview, the LALD-A and the ESD-F acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty (21) days	0 810		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure refrigerated medications were maintained at manufactured recommended temperatures by failing to monitor and document medication refrigerator temperatures located in one of one refrigerator where resident medications were stored. 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	01880		

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01880	Continued From page 9 portion or all of the residents). The findings include: On February 14, 2023, at 9:40a.m., the medication refrigerator located on the second floor, in the nursing station was observed, and found to have resident's medications stored in the refrigerator. Temperature logs from December 2022, January 2023, and February 2023 were requested and reviewed. The refrigerator log for December 2022 lacked temperature readings for twelve of thirty-one days, the refrigerator log for January 2023 lacked temperature readings for sixteen of thirty-one days, the refrigerator temperature log for February 2023 lacked temperature readings for five of fourteen days. The refrigerator contained the following medications for R7, R8, R9, R10: R7, R8: Lantus SoloStar insulin pens The manufacturer's instructions for Lantus SoloStar insulin pens dated August 2022, indicated before opening, store the insulin pens in the refrigerator between 36 to 46 degrees F. Do not allow the Lantus SoloStar to freeze. R7: Ozempic insulin pens The manufacturer's instructions for Ozempic insulin pens dated, June 2022, indicated before opening, store the insulin pens in the refrigerator between 36 to 46 degrees F. Do not allow the Ozempic to freeze. R8: NovoLog Flex pens The manufacturer's instructions for NovoLog Flex pens dated, 2020, indicated before opening, store the insulin pens in the refrigerator between 36 to 46 degrees F.	01880		

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01880	Continued From page 10 R9: Latanoprost solution The manufacturer's instructions for Latanoprost solution dated, August 2011, indicated before opening, store the ophthalmic solution in the refrigerator between 36 to 46 degrees F. R10: Stelara injections The manufacturer's instructions for Stelara injections, dated July 2022, indicated before opening, store the ophthalmic solution in the refrigerator between 36 to 46 degrees F. Do not allow Stelera to freeze. On February 14, 2023, at 9:45 a.m., registered nurse (RN)-E stated the medication storage logs were a nursing task that was supposed to be completed on the day shift, but they just did not complete them. On February 14, 2023, at 12:20 p.m., licensed assisted living director (LALD)-A stated she was unable to find documentation indicating the temperature of the medication refrigerators were logged at any other place in the facility. The licensee's Storage of Medication and Key Security policy dated September 27, 2021, indicated medications requiring refrigeration would be kept in a refrigerator with temperatures ranging between 36 to 46 degrees F, and would have a thermometer to allow temperature monitoring daily. Furthermore, if the temperature range went out of the noted temperature range, the nurse would review each medication and notify the manufacture to review if the medication would need to be discarded. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01880		

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01880	Continued From page 11 days	01880		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were labeled correctly for one of one hundred thirty-nine residents (R8). 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). Findings include: On February 14, 2023, at 8:50 a.m., surveyor observed unlicensed personnel (ULP)-D prepare a Novolog Flexpen for administration to R8. R8's insulin injectable pen prepared by ULP-D lacked a label that provided both the dates the medication had been opened and the expiration date. The insulin pen prepared by ULP-D	01890		

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THE SANCTUARY AT WEST ST PAUL	1746 OAKDALE AVENUE WEST SAINT PAUL, MN 55118

(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
01890	Continued From page 12 included: - Novolog Flexpen 100U (units)/ml (milliliter) Manufacturer's instructions for Novolog Flexpen indicated the pen should be discarded after 28 days. On February 14, 2023, at 9:00 a.m., ULP-D verified that there was no date opened or expiration date on R8's Novolog Flex Pen and stated, "the medication passer is usually the one that puts the date opened and expiration date on the insulin pens when opened." On February 14, 2023, at 9:45 a.m., registered nurse (RN)-E confirmed all insulin pens should be dated when opened. RN-E stated, "the lead RA is responsible for auditing the medication cart." A policy addressing Medication Prescriptions and Treatment Content was received; the policy did not address the use of insulin pens. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01890		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to	02040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32587	A. BUILDING: _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SANCTUARY AT WEST ST PAUL	1746 OAKDALE AVENUE WEST SAINT PAUL, MN 55118

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02040	Continued From page 13 protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on the document review and interview, the licensee failed to develop a safety risk assessment plan to identify hazard vulnerabilities and mitigations on and around the property to protect memory care residents from harm. This has the potential to directly affect staff, visitors, and all memory care residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients). The findings include: On February 15, 2023, at approximately 3:45 p.m., a document review indicated the license failed to develop the site-specific safety risk assessment and mitigation plan on and around the property to protect the memory care residents from harm. This finding was evident as there was no site-specific plan documentation was provided for review. The finding was confirmed during the interview with the environment services director (ESD)-F and the licensed assisted living director (LALD)-A at 4:00 p.m. that the facility lacked a plan.	02040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32587	A. BUILDING: _____ B. WING _____	02/16/2023

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02040	Continued From page 14 On February 15, 2023, at approximately 4:30 p.m., during the exit interview survey staff discussed the findings and explained to the LALD-A and the ESD-F that all potential safety risks or vulnerabilities on and around the property must be identified, assessed, and mitigated and be documented in the plan documentation to protect the memory care residents from harm. The LALD-A acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		

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

Type: Full
Date: *02/15/23*
Time: 11:00:00
Report: 1005231033

Food and Beverage Establishment Inspection Report

Location:
The Sanctuary At West St Paul
1746 Oakdale Avenue
West St Paul, MN55118
Dakota County, 19

Establishment Info:
ID #: 0037873
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 6514556322
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.

3-300A Protection from Contamination: limit hand contact, tasting

3-301.11A ** Priority 1 **

MN Rule 4626.0225A Discontinue bare hand contact with ready-to-eat foods. Use deli tissue, spatulas, tongs, single-use gloves or other dispensing equipment.

OBSERVED EMPLOYEE TOUCH FRENCH FRIES AND HAMBURGER BUN WITH BARE HANDS. DISCUSSED USING TONGS OR WEARING GLOVES WHEN HANDLING READY-TO-EAT FOODS.

Comply By: 02/15/23

3-500B Microbial Control: hot and cold holding

3-501.16A2 ** Priority 1 **

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

MILK IN REACH-IN COOLER #2 WAS 44 DEGREES F. ADJUST COOLER TO A COLDER SETTING, OR REPAIR IF NECESSARY.

Comply By: 02/15/23

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 DIGITAL, IN-LINE THERMOMETER IN REACH-IN COOLER #2 WAS READING 37 DEGREES F, BUT FOOD TEMPERATURES WERE 44 DEGREES F. PROVIDE AN AMBIENT THERMOMETER IN THE FRONT OF THE BOTTOM SHELF, WHERE IT IS WARMEST.

Comply By: 02/22/23

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

MN Rule 4626.1520A Clean and maintain all physical facilities clean.

THROUGHOUT THE KITCHEN, THERE IS AN ACCUMULATION OF DUST ON THE CEILING AROUND THE VENTS.

Comply By: 02/22/23

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200PPM at Degrees Fahrenheit
Location: WIPING CLOTH BUCKET
Violation Issued: No

Quaternary Ammonia: = 400PPM at Degrees Fahrenheit
Location: WIPING CLOTH BUCKET
Violation Issued: No

Quaternary Ammonia: = 400PPM at Degrees Fahrenheit
Location: 3-COMP DISPENSER
Violation Issued: No

Utensil Surface Temp.: = at 174 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Hot Hold/SOUP
Temperature: 180 Degrees Fahrenheit - Location: STEAM TABLE
Violation Issued: No

Process/Item: Cold Hold/SLICED TOMATO
Temperature: 40 Degrees Fahrenheit - Location: PREP COOLER
Violation Issued: No

Process/Item: Cold Hold/TUNA SALAD
Temperature: 39 Degrees Fahrenheit - Location: PREP COOLER
Violation Issued: No

Process/Item: Cold Hold/HOT DOG
Temperature: 39 Degrees Fahrenheit - Location: PREP COOLER
Violation Issued: No

Process/Item: Cold Hold/MILK
Temperature: 44 Degrees Fahrenheit - Location: NORLAKE REACH-IN #2
Violation Issued: Yes

Process/Item: Cold Hold/JUICE
Temperature: 38 Degrees Fahrenheit - Location: NORLAKE REACH-IN #1
Violation Issued: No

Food and Beverage Establishment Inspection Report

Process/Item: Cooking/BURGER
Temperature: 185 Degrees Fahrenheit - Location: GRILL
Violation Issued: No

Process/Item: Cooking/CHICKEN
Temperature: 205 Degrees Fahrenheit - Location: FRYER
Violation Issued: No

Process/Item: Cold Hold/CUT MELON
Temperature: 36 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Hold/NOODLES
Temperature: 38 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Hold/TACO MEAT
Temperature: 37 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Hold/HAM
Temperature: 37 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Hold/AMBIENT
Temperature: 38 Degrees Fahrenheit - Location: MEMORY CARE REACH-IN COOLER
Violation Issued: No

Process/Item: Hot Hold/CAULIFLOWER
Temperature: 200 Degrees Fahrenheit - Location: MEMORY CARE STEAM TABLE
Violation Issued: No

Process/Item: Hot Hold/CHICKEN
Temperature: 174 Degrees Fahrenheit - Location: MEMORY CARE STEAM TABLE
Violation Issued: No

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

INSPECTION COMPLETED WITH FOOD SERVICE DIRECTOR AND EMAILED TO HRD NURSE EVALUATOR, MARY BRUESS. DISCUSSED ALL ORDERS ON REPORT.

DISCUSSED COOLING, DATE-MARKING, COOKING TEMPERATURES, AND EMPLOYEE ILLNESS.

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 1005231033 of 02/15/23.

Certified Food Protection Manager: JACQUES N. PHILIPPON

Certification Number: FM10742 Expires: 02/27/25

Inspection report reviewed with person in charge and emailed.

Signed: _____

JACQUES PHILIPPON
FOOD SERVICE DIRECTOR

Signed: Jessica Davis

Jessica Davis
Public Health Sanitarian III
651-201-3961
jessica.davis@state.mn.us