



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

March 23, 2026

Licensee

Golden Touch Health Care LLC

8216 Hampshire Court North

Brooklyn Park, MN 55445

RE: Project Number(s) SL35842016

Dear Licensee:

On January 27, 2026, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on October 31, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the October 31, 2025 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on October 31, 2025, found not corrected at the time of the January 27, 2026, follow-up survey and/or subject to penalty assessment are as follows:

0810-Fire Protection And Physical Environment-144g.45 Subd. 2 (b-F) - \$1,000.00

The details of the violations noted at the time of this follow-up survey completed on January 27, 2026 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Also, at the time of this follow-up survey completed on January 27, 2026, we identified the following violation(s):

0340-Correction Orders-144g.30 Subd. 5 - \$1,000.00

The details of the violation(s) noted at the time of this follow-up survey are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these state correction orders. It is not necessary to develop a plan of correction.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$2,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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 outlined on the state form; however, plans of correction are not

required to be submitted for approval.

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;

Level 3: a fine of \$1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 4: a fine of \$3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 5: a fine of \$5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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>

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration or a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

We urge you to review these orders carefully. If you have questions, please contact Stephanie Jones

de Palma at 651-201-4320.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and/or state form with your organization's Governing Body.

Sincerely,

A handwritten signature in black ink, reading "Stephanie Jones de Palma". The signature is fluid and cursive, with a large, stylized initial 'S'.

Stephanie Jones de Palma, Supervisor
State Rapid Response Team / State Evaluation Team
Email: stephanie.jones.de.palma@state.mn.us
Telephone: 651-201-4320 Fax: 1-800-337-9238 / 1-866-890-9290

KKM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35842	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 01/27/2026
NAME OF PROVIDER OR SUPPLIER GOLDEN TOUCH HEALTH CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 8216 HAMPSHIRE COURT NORTH BROOKLYN PARK, MN 55445			
(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 FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL35842016-1 On 1/26/26, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on 10/31/2026. At the time of the survey, there were 4 residents; 4 receiving services under the Assisted Living license. As a result of the follow-up survey, the following orders were issued and/or reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.		
0 340 SS=I	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or staff of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of	0 340			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 340	Continued From page 1 noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must: (1) document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed; and This MN Requirement is not met as evidenced by: This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) 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 a survey that was conducted October 31, 2025, the licensee was cited using the 0810 tag identification number for failing to provide a fire safety and evacuation plan (FSEP) that included staff actions to take in the event of a fire or similar emergency, resident procedures for evacuation, for failing to provide training of staff on the FSEP at time of hire and at least twice per year after,	0 340			

Minnesota Department of Health

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0 340	Continued From page 2 and for failing to conduct emergency evacuations drills twice per year per shift with at least one evacuation drill every other month. On January 26, 2026, survey staff confirmed the deficient condition remained, as the licensee failed to provide a FSEP that included staff actions to take in the event of a fire or similar emergency, resident procedures for evacuation, for failing to provide training of staff on the FSEP at time of hire and at least twice per year after, and for failing to conduct emergency evacuations drills twice per year per shift with at least one evacuation drill every other month. INTERVIEW: The surveyor conducted a telephone interview on January 26, 2026, with administrator (A)-A. A-A stated that they had not updated their policy and had reached out to their consultant and asked them to provide the facility with an updated FSEP. A-A could not provide a date for when they had reached out to their consultant. A-A was unable to provide an estimated timeframe for when their consultant was going to provide the new policy. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340			
{0 470} SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet	{0 470}			

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{0 470}	Continued From page 3 the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 470}			
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with	{0 480}			

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{0 480}	Continued From page 4 one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part	{0 480}			

Minnesota Department of Health
STATE FORM 6899 P24W12 If continuation sheet 6 of 10

Minnesota Department of Health

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{0 570}	Continued From page 6 any person who requests it. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 570}			
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 800}			
{0 810} SS=I	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) staff 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	{0 810}			

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{0 810}	Continued From page 7 or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) 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:	{0 810}			

Minnesota Department of Health

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{0 810}	Continued From page 8 On January 26, 2026, the surveyor initiated a follow-up survey on orders issued pursuant to a survey completed on October 31, 2025. The surveyor requested updated fire safety and evacuation policy (FSEP) that included staff and resident actions, staff training on the facilities FSEP, and emergency evacuation drills. Unlicensed personnel (ULP)-G stated that they were not aware of what the surveyor was asking for and contacted administrator (A)-A via phone. On January 26, 2026, at 12:05 p.m. A-A was interviewed via phone. A-A stated that they had reached out to their consultant and asked them to provide the facility with an updated FSEP. A-A could not provide a date for when they had reached out to their consultant. A-A was unable to provide an estimated timeframe for when their consultant was going to provide the new policy. A-A stated that once they receive the new policy, they will train staff on the new policy. No documentation was provided for review.	{0 810}			
{03090} SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by:	{03090}			

Minnesota Department of Health

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{03090}	Continued From page 9 Not reviewed during this survey.	{03090}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

November 18, 2025

Licensee

Golden Touch Health Care LLC

8216 Hampshire Court North

Brooklyn Park, MN 55445

RE: Project Number(s) SL35842016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 31, 2025, 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.

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 . . ."

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;

Level 3: a fine of \$1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 4: a fine of \$3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 5: a fine of \$5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are

assessed pursuant to this survey:

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - \$1,000.00

St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - \$1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$2,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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.

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<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

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To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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,

A handwritten signature in cursive script that reads "Renee L. Anderson". The signature is written in dark ink and is positioned below the "Sincerely," text.

Renee L. Anderson, Supervisor

State Evaluation Team

Email: Renee.L.Anderson@state.mn.us

Telephone: 651-201-5871 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35842	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/31/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN TOUCH HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 8216 HAMPSHIRE COURT NORTH BROOKLYN PARK, MN 55445		
(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 In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: SL35842016-0 On October 27, 2025, through October 31, 2025, the Minnesota Department of Health conducted an initial survey at the above provider, and the following correction orders are issued. At the time of the survey, there were three (3) residents who were receiving services under the provider's Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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 SUBDIVISION 1-3.		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements	0 470			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 470	Continued From page 1 (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the required staffing plan was posted for residents, staff, and visitors to review as required. This had the potential to affect all three (3) residents, staff, and visitors. This practice resulted in a level two violation (a	0 470			

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0 470	Continued From page 2 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 October 27, 2025, at 11:50 a.m., during a self-guided facility tour of licensee's main floor and common areas, the surveyor observed no posted daily staffing schedule. The licensee lacked a posted daily staffing schedule developed by the clinical nurse supervisor to: - include direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked; - identify the direct-care staff member's resident assignments or work; and - be posted after redacting direct-care staff member's resident assignments, at the beginning of each work shift in a central location in each building. On October 27, 2025, at 12:11 a.m., administrator (A)-A stated licensee lacked a posted staffing plan in a common area of the facility. A-A further stated licensee had one big posting posted at the front entrance of the facility, with the required information on it, along with individual postings on the wall in the kitchen area; however, the residents kept taking them down.	0 470			

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0 470	Continued From page 3 The licensee's Staffing and Scheduling policy dated August 1, 2021, indicated the daily work schedule would be posted, after redacting direct-care staff members' resident assignments, at the beginning of each work shift in a central location in each building of a facility or campus, accessible to staff, residents, volunteers, and the public. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470			
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to	0 480			

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0 480	Continued From page 4 provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. 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	0 480			

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0 480	Continued From page 5 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 October 28, 2025, 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			
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the	0 550			

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0 550	Continued From page 6 Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the required information about the licensee's grievance procedure, including the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances, as well as information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). This had the potential to affect all of the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On October 27, 2025, at 11:50 a.m., during a self-guided facility tour of licensee's main floor and common areas, the surveyor observed the entry area and common areas. The licensee lacked a posting of the grievance procedure, in a conspicuous place, with the following required information: - name, telephone number, and e-mail contact information for the individuals who would be responsible for handling resident grievances, and - information for reporting suspected	0 550			

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0 550	Continued From page 7 maltreatment to the Minnesota Adult Abuse Reporting Center. On October 27, 2025, at 12:11 a.m., administrator (A)-A stated licensee lacked a posted grievance procedure, in a common area of the facility. A-A further stated licensee had one big posting posted at the front entrance of the facility, with the required information on it, along with individual postings on the wall in the kitchen area; however, the residents kept taking them down. The licensee's Complaint/Grievance Posting policy dated August 1, 2021, indicated the licensee would post, in a conspicuous place, information about their complaint/grievance procedure, and the name, telephone number, and email contact information for the individual(s) who would be responsible for handling resident complaints/grievances. In addition, the posting would include information for reporting suspected maltreatment to MAARC. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550			
0 570 SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	0 570			

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0 570	Continued From page 8 review, the licensee failed to display the original current license at the main entrance of the assisted living facility as required. This had the potential to affect all of the licensee's three (3) current residents, staff and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On October 27, 2025, at 11:50 a.m., during a self-guided facility tour, the surveyor observed a current, original license posted to the wall of the main entry way of the facility. The license was for a different facility, and included a different address and license number than the licensee. On October 27, 2025, at 12:20 p.m., administrator (A)-A stated the license at the front entrance was for a sister facility, and had the same expiration date as the surveyed facility, so he was unaware the correct license was not posted. The licensee's Assisted Living License and Posting policy dated August 1, 2021, indicated licensee would maintain a current Assisted Living License issued by the Minnesota Department of Health (MDH), and the current license would be displayed at the main entrance of the facility. No further information provided.	0 570			

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0 570	Continued From page 9	0 570			
0 775 SS=I	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with Minnesota State Fire Code in Minnesota Rules chapter 7511. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On October 29, 2025, the surveyor toured the facility with administrator (A)-A. The following was observed: -Inside of resident room 1 there was a green plastic tray sitting on the bed that had ash and black marks. A-A stated that they were not aware that the resident smoked.	0 775			

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0 775	Continued From page 10 -In resident room 3 there was burn marks on a table. There was also a burnt piece of wood and ash from cigarettes along with loose tobacco on the table. A-A identified the front stoop as a place that smoking takes place. There was a plastic container that was half full of cigarette butts. A-A also identified the rear deck as a place where smoking takes place. There were cigarette butts stuck between the wooden deck boards, burn marks in the wooden deck boards, and burn marks in the vinyl siding next to the sliding door. Smoking shall be done safely, and cigarettes discarded into approved non-combustible ash trays placed on a sturdy surface. Lighted matches, cigarettes, cigars or other burning object shall not be discarded in such a manner that could cause ignition of other combustible material. TIME PERIOD FOR CORRECTION: Two (2) days	0 775			
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.	0 800			

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0 800	Continued From page 11 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain 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. This deficient condition had the potential to affect all staff, residents, 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 the potential to affect a large portion or all of the residents). The findings include: On October 29, 2025, the surveyor toured the facility with administrator (A)-A. The following was observed: -Throughout the facility there were patches in the drywall that were incomplete drywall repairs. The walls throughout the facility were also covered in stains and not being maintained in a sanitary condition. A-A stated that they had a resident that has since been discharged that was destructive to the facility. A-A stated that they were in the process of painting the walls, but did not have a timeline for the repairs.	0 800			

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0 800	Continued From page 12 -On the first floor the room that A-A identified as storage and resident room 2 lacked a floor covering. The subflooring was exposed as well as tack strips throughout the room. In the room identified as storage, there was also a hole in one of the walls as well as all the walls being stained and not being maintained in a sanitary condition. -On the first-floor bathroom there was a missing floor tile at the hallway. There was also a hole in the door. The cover for the vent fan was missing. -In the lower-level bathroom, the walls were damaged near the shower. -There were several unfinished wall patches in resident room 4. A-A stated that they were in the process of painting the walls, but did not have a timeline for the repairs. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800			
0 810 SS=I	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) staff 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	0 810			

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0 810	Continued From page 13 emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35842	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/31/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN TOUCH HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 8216 HAMPSHIRE COURT NORTH BROOKLYN PARK, MN 55445		
(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
0 810	Continued From page 14 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On October 29, 2025, administrator (A)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but the plan was designed for a building with life safety systems such as fire doors and smoke compartments. The policy had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility which did not have life safety systems or a fire-resistant construction type. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. TRAINING: The licensee failed to provide training to employees on the FSEP upon hire and at least	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35842	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/31/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN TOUCH HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 8216 HAMPSHIRE COURT NORTH BROOKLYN PARK, MN 55445		
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0 810	Continued From page 15 twice per year. A-A lacked documentation showing any training was offered or training was scheduled for a future date for staff on the FSEP. DRILLS: The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Record review of licensee's evacuation drill log, indicated evacuation drills were conducted on April 21, 2025, and August 23, 2025. Drills shall be conducted twice per year per shift with at least one evacuation drill every other month. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the required notice was posted at all entrances to the establishment to display statutory language to disclose electronic monitoring activity. This had the potential to affect all current residents in the assisted living facility, staff, and visitors.	03090			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35842	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/31/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN TOUCH HEALTH CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 8216 HAMPSHIRE COURT NORTH BROOKLYN PARK, MN 55445			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
03090	Continued From page 16 This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On October 27, 2025, at 9:50 a.m., the surveyor observed outside the front entrance and just inside the front entrance to the facility. There was no required posting for electronic monitoring devices. On October 27, 2025, at 11:50 a.m., during a self-guided facility tour of licensee's main floor and common areas, the surveyor observed the entry area and common areas and noted there were cameras present within the facility; however, no posting at the facility entrance including the statutory language for electric monitoring. On October 27, 2025, at 12:11 a.m., administrator (A)-A stated licensee had cameras throughout the facility, however, they had been broken by the residents. A-A further stated the electronic monitoring notice had been posted on the front entry door; however, the residents had taken it down. A-A further stated that he was about to post another notice. The licensee's Electronic Monitoring policy dated August 1, 2021, indicated in compliance with MN Statute §144.6502, licensee would make	03090			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35842	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/31/2025
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03090	Continued From page 17 available to all residents, an approved Electronic Monitoring notification and consent form, and inform residents and visitors of their option to conduct electronic monitoring within the general living areas of the facility. Furthermore, a conspicuous posting would be placed in general area for all visitors and residents alike to see. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090			



Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Page: 1

Establishment Info

GOLDEN TOUCH HEALTH CARE LLC
8216 HAMPSHIRE COURT NORTH
Brooklyn Park, MN 55445
Hennepin County
Parcel:

Phone:

License Info

License: HFID 35842

Risk:
License:
Expires on:
CFPM: Sheikh K. Dukuly II
CFPM #: FM109724; Exp: 2/11/2028

Inspection Info

Report Number: F1043251250
Inspection Type: Full - Single
Date: 10/28/2025 Time: 1:03:51 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 2
Total Priority 3 Orders: 4
Delivery:

New Order: 2-500 Cleanup of Vomiting and Diarrheal Events

2-501.11 Priority Level: Priority 2 CFP#: 5

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

COMMENT: NO SPILL KIT OR CLEAN UP PROCEDURES AVAILABLE. ADVISED STAFF TO PROVIDE AT LEAST ONE OPTION AND HAVE IT READILY AVAILABLE. COMPLY WITH ABOVE RULE.

Comply By: 10/28/2025 Originally Issued On: 10/28/2025

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

3-304.14B Priority Level: Priority 3 CFP#: 41

MN Rule 4626.0285B Wiping cloths used for wiping counters and other equipment surfaces must be held in an approved sanitizing solution and laundered daily.

COMMENT: WET CLOTH STORED ON DIVIDER OF COMPARTMENT SINK. ADVISED STAFF TO STORE IN-USE CLOTHS IN A SANITIZING SOLUTION IN BETWEEN USES (SANITIZER TEST KIT REQUIRED), ALTERNATIVE OPTIONS PROVIDED. COMPLY WITH ABOVE RULE.

Comply By: 10/28/2025 Originally Issued On: 10/28/2025

New Order: 3-500C Microbial Control: date marking

3-501.17A Priority Level: Priority 2 CFP#: 23

MN Rule 4626.0400A Mark the refrigerated, ready-to-eat, TCS food prepared 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.

COMMENT: OPENED CONTAINER OF DELI MEAT OBSERVED WITH NO DATE MARK. STAFF CONFIRMED CONTAINER WAS OPENED ON 10/27/25. ADVISED STAFF TO DATE MARK AND DISCARD LEFTOVER TCS FOODS AFTER 7 DAYS. CORRECTED ONSITE. COMPLY WITH ABOVE RULE.

Comply By: 10/28/2025 Originally Issued On: 10/28/2025

New Order: 4-500 Equipment Maintenance and Operation

4-501.11AB Priority Level: Priority 3 CFP#: 47

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

COMMENT: DOOR TO MICROWAVE ABOVE STOVE OBSERVED TO BE MISSING PARTS. PER STAFF, MICROWAVE IS NOT OPERATIONAL. ADVISED STAFF TO REPAIR/REPLACE/REMOVE EQUIPMENT. COMPLY WITH ABOVE RULE.

Comply By: 10/28/2025 Originally Issued On: 10/28/2025

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control6-501.11 *Priority Level: Priority 3 CFP#: 55**MN Rule 4626.1515* Maintain the physical facilities in good repair.

COMMENT: REPEAT SINCE 10/30/23: (1) COUNTER TOP BOARD BEHIND KITCHEN SINK LOOSE FROM WALL AND SURFACE COVERING LOOSE FROM BOARD EXPOSING INTERIOR, ABSORBABLE MATERIAL. (2) MULTIPLE KITCHEN CABINET DOORS MISSING. ADVISED STAFF TO REPAIR/REPLACE. PER STAFF, REPAIRS ARE IN PROGRESS. COMPLY WITH ABOVE RULE.

*Comply By: 10/28/2025 Originally Issued On: 10/28/2025***New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control**6-501.12A *Priority Level: Priority 3 CFP#: 55**MN Rule 4626.1520A* Clean and maintain all physical facilities clean.

COMMENT: REPEAT SINCE 10/30/23: SPLATTERS AND STAINS ON KITCHEN CEILING AND WALLS. ADVISED STAFF TO CLEAN AND MAINTAIN CLEAN. COMPLY WITH ABOVE RULE.

Comply By: 10/28/2025 Originally Issued On: 10/28/2025

Food & Beverage General Comment

Inspection was completed with Rhonda Makela as the lead Health Regulation Division Nurse Evaluator completing the site survey.

FOOD TEMPERATURE (F)

FRIDGE: MILK 41, DELI MEAT 41, CHEESE 41

UTENSIL SURFACE TEMPERATURE (F)

DISH MACHINE: 160

Discussed highly susceptible populations, date marking, illness policy, sanitizer use, ware washing, temperature control, same day service, cleaning, pest control, vomit/fecal procedures, test kits, food storage, and food handling procedures.

Foods cooked in house are for same day service, leftovers are discarded by end of day.

Facility has a residential kitchen with residential equipment, wooden cabinetry, laminated flooring, smooth walls, and textured ceilings. Dish machine has a sani rinse option. Sanitizing option on dish machine must always be used when running a cycle. Equipment and physical facility will be monitored during future inspections.

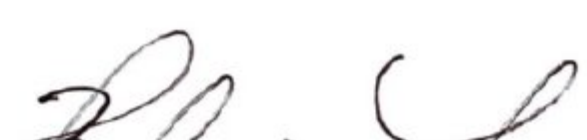
Contact Health Regulation Division for plan review approval when facility/kitchen undergoes remodeling, major equipment additions, or changes of equipment due to a menu change.

***Notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation.

If any customer complains of illness, establishment is required to notify the Minnesota Department of Health and provide the foodborne illness hotline phone number to the customer: 1-877-366-3455

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Metro District Office inspection report number F1043251250 from 10/28/2025



Blia Lor

Ishmael Komara
PIC

Blia Lor,
Public Health Sanitarian 1
651-355-0641
blia.lor@state.mn.us