



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

June 7, 2023

Licensee
Trails Of Orono Assisted Living
875 Wayzata Boulevard
Orono, MN 55391

RE: Project Number(s) SL28637015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 24, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the 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. The MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

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

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

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

the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS

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

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

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).

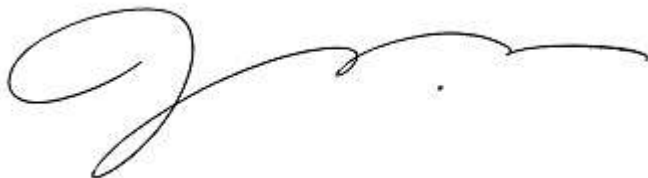
Please address your cover letter for reconsideration requests to:

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 the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,

A handwritten signature in black ink, appearing to read 'Jess Schoenecker', with a stylized flourish at the end.

Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 651-281-9796
PMB

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28637	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/24/2023
NAME OF PROVIDER OR SUPPLIER TRAILS OF ORONO ASSISTED LIVIN		STREET ADDRESS, CITY, STATE, ZIP CODE 875 WAYZATA BOULEVARD ORONO, MN 55391		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When the Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL28637015 On May 22, 2023, through May 24, 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 56 active residents; 54 receiving services under the Assisted Living/Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated May 24, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b) The facility's infection control program must be consistent with current guidelines from the	0 510		

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0 510	Continued From page 2 national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to establish and maintain an infection control program that complies with accepted health care, medical and nursing standards for infection control. The deficient practice had the potential to affect residents, employees, 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On May 22, 2023, at approximately 12:00 p.m., unlicensed personnel (ULP)-C entered R2's room to provide medication administration on R2. ULP-C failed to perform hand hygiene prior to R2's medication administration. On May 22, 2023, at approximately 12:15 p.m., ULP-C stated: "I know my mistake, I didn't wash my hands."	0 510		

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0 510	Continued From page 3 On May 23, 2022, at approximately 11:30 a.m., clinic nursing supervisor (CNS)-B indicated all staff should be performing hand hygiene prior to entering resident rooms and after exiting resident rooms. The licensee's Standard Infection Control Precautions policy dated August 1, 2022, indicated staff would perform hand hygiene between all client contacts. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not	0 680		

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0 680	Continued From page 4 received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all residents, employees, and visitors to the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 May 22, 2023, at approximately 11:30 a.m., licensed assisted living director (LALD)-A provided a binder and indicated the contents were the licensee's EP plan. The licensee's EP plan, undated, lacked documentation of EP plan reviewed on an annual basis. On May 22, 2023, at approximately 1:00 p.m., LALD-A acknowledged the licensee's EP plan lacked the annual review and stated "the EP plan has been a work in progress." The licensee's Emergency Operations Program	0 680		

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0 680	Continued From page 5 Plan document, undated, indicated the licensee would review the EP plan at least annually. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 800		

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0 800	Continued From page 6 On May 23, 2023, at approximately 10:00 a.m., survey staff toured the facility with Licensed Assisted Living Director (LALD)-A and Environment Service Director (ESD)-F. During the facility tour, survey staff observed the following: The first floor's club room doors were fire-rated and propped open with door wedges. The rubber wedge would prevent the doors from closing properly in the event of a fire. The first floor's dining room doors were fire-rated and propped open with door wedges. The rubber wedge would prevent the doors from closing properly in the event of a fire. The restroom door by dining on the first floor, the door closer had been disabled by removing the closure arm or closure device. The door had a portion or remnants of the closure device still mounted on the door. The kitchen door on the first floor was fire-rated and propped open by chain and hook. The chain and hook would prevent the door from closing properly in the event of a fire. During the facility tour interview, LALD-A and ESD-F visually verified these deficient findings at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring	01620		

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01620	Continued From page 7 (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment no more than 90 days after the previous assessment for three of five residents (R2, R5, R6). 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	01620		

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01620	Continued From page 8 or has the potential to affect a large portion or all of the residents). The findings include: R2 R2 was admitted on June 20, 2019. R2's 90-day Assessment was completed on October 7, 2022, with the next assessment due within 90 days or by January 5, 2023. R2's record included a late 90-day assessment dated March 1, 2023. R5 R5 was admitted on November 2, 2022. R5's 90-day Assessment was completed on November 29, 2022, with the next assessment due within 90 days or by February 27, 2023. R5's record included a late 90-day assessment dated March 13, 2023. R6 R6 was admitted on April 28, 2022. R6's 90-day Assessment was completed on November 11, 2022, with the next assessment due within 90 days or by February 9, 2023. R6's record included a late 90-day assessment dated March 6, 2023. On May 23, 2023, at 12:10 p.m., registered nurse (RN)-D indicated the licensee was aware resident assessments were more than 90 days between assessments due to a new assessment format by Ebenezer but are now catching up with completing assessments within the required timeframes.	01620		

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01620	Continued From page 9 The licensee's Assessment of Clients - Initial and Ongoing policy dated May 23, 2022, indicated licensee would complete ongoing resident assessment not to exceed 90 calendar days from the resident's last date of the assessment. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01880 SS=D	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 maintain a temperature log to ensure appropriate storage of refrigerated medications for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	01880		

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01880	Continued From page 10 On May 23, 2023, at approximately 9:00 a.m., surveyor observed a locked medication refrigerator inside R2's bedroom that lacked a temperature log and thermometer. The medication lorazepam 2 milligram (mg)/milliliter (ml) (0.5mg/0.25ml by mouth every two hours as needed for anxiety, insomnia, or severe nausea) was observed stored in the refrigerator. Manufacturer storage directions for lorazepam 2 mg/ml dated October 2012, indicated protect from light and store at cold temperature-refrigerate at 36°F [degrees Fahrenheit] to 46°F. On May 23, 2023, at 9:45 a.m., clinical nurse supervisor (CNS)-B verified no thermometer was present in R2's medication refrigerator, and a daily log of refrigerator temperatures was not available and was unsure why. The licensee's Storage of Medication and Key Security policy dated April 19, 2023, indicated medications requiring refrigeration or temperatures between 36°F to 46°F are kept in a refrigerator with a thermometer to allow temperature monitoring daily and will be stored consistent with manufacturer's recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) 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	01890			

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01890	Continued From page 11 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 and interview, the licensee failed to dispose of an expired medication into an appropriate pharmaceutical waste container for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On May 23, 2023, at approximately 9:00 a.m., surveyor observed unlicensed personnel (ULP)-C provide medication administration on R2. ULP-C identified a partially used medication (dorzolamide hcl and timolol maleate ophthalmic solution 22.3 milligram (mg)/6.8 mg per ml used to treat glaucoma) for R2 that expired on May 9, 2023. ULP-C then disposed of Dorzolamide HCl and timolol maleate ophthalmic medication into R2's kitchen trash receptacle. On May 23, 2023, at 11:30 p.m., clinic nurse supervisor (CNS)-B indicated licensee has central location for disposal of expired medications, and ULP-C should of gave the expired medication to a registered nurse (RN) for disposal.	01890		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28637	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/24/2023
NAME OF PROVIDER OR SUPPLIER TRAILS OF ORONO ASSISTED LIVIN		STREET ADDRESS, CITY, STATE, ZIP CODE 875 WAYZATA BOULEVARD ORONO, MN 55391		
(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 The licensee's Disposition of Medication/Legend and Controlled Substances policy dated December 2, 2020, indicated the licensee would assure that any expired medications would be disposed of in collection containers marked for pharmaceutical waste, and a RN is responsible for placing expired medications in the appropriate pharmaceutical waste container. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

Type: Full
Date: 05/24/23
Time: 16:00:00
Report: 8087231104

Food and Beverage Establishment Inspection Report

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Location:

Trails Of Orono Assisted Livin
875 Wayzata Boulevard
Orono, MN55391
Hennepin County, 27

Establishment Info:

ID #: 0039187
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9524736655
ID #:

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

The following orders were issued during this inspection.

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment. THERE IS NO FULL TIME STATE CERTIFIED FOOD PROTECTION MANAGER AT THE ESTABLISHMENT. HIRE A FULL TIME EMPLOYEE OR TRAIN AN EXISTING FULL TIME EMPLOYEE AND APPLY FOR THE STATE CERTIFIED FOOD PROTECTION MANAGER CERTIFICATE.

Comply By: 07/01/23

Surface and Equipment Sanitizers

Quaternary Ammonia: = 400 PPM at -- Degrees Fahrenheit
Location: WALL DISPENSING UNIT
Violation Issued: No

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

Wash Temperature Gauge: = -- at 160 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Rinse Temperature Gauge: = -- at 188 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Max Utensil Surface Temp: = -- at 164 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Type: Full
Date: 05/24/23
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Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: CHEESE
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: LIQUID EGG
Violation Issued: No

Process/Item: Ambient Air
Temperature: -19 Degrees Fahrenheit - Location: STAND-UP FREEZER
Violation Issued: No

Process/Item: Ambient Air
Temperature: 41 Degrees Fahrenheit - Location: STAND-UP COOLER
Violation Issued: No

Process/Item: Cold Holding: CUT MELON
Temperature: 39 Degrees Fahrenheit - Location: STAND-UP COOLER
Violation Issued: No

Process/Item: Cold Holding: YOGURT
Temperature: 40 Degrees Fahrenheit - Location: STAND-UP COOLER
Violation Issued: No

Process/Item: Ambient Air
Temperature: 33 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding: DELI MEAT
Temperature: 34 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding: CHEESE
Temperature: 34 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding: CUT MELON
Temperature: 34 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Thawing: FISH
Temperature: 21 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Thawing: CHICKEN
Temperature: 19 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Ambient Air
Temperature: 1 Degrees Fahrenheit - Location: WALK-IN FREEZER
Violation Issued: No

Type: Full
Date: 05/24/23
Time: 16:00:00
Report: 8087231104
Trails Of Orono Assisted Livin

Food and Beverage Establishment Inspection Report

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

THIS WAS AN UNANNOUNCED AND UNSCHEDULED FULL INSPECTION.

INSPECTION DONE WITH KITCHEN MANAGER NICHOLAS MURRAY.

TOPICS OF DISCUSSION WITH OPERATOR INCLUDED:

HAND WASHING
NOROVIRUS
BARE HAND CONTACT WITH READY TO EAT FOODS
EMPLOYEE ILLNESS
EMPLOYEE EXCLUSION
COOLING METHODS
REHEATING METHODS
SANITIZER CONCENTRATION
DATE MARKING
ALL ITEMS ON THIS REPORT
ALL ITEMS ON PREVIOUS REPORT

ALL FROZEN FOODS FOUND IN FROZEN CONDITION.

REPORT EMAILED TO ESTABLISHMENT.

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 8087231104 of 05/24/23.

Certified Food Protection Manager: _____

Certification Number: _____ Expires: ____ / ____ / ____

Inspection report reviewed with person in charge and emailed.

Signed: _____

NICHOLAS MURRAY
KITCHEN MANAGER

Signed: _____

John Boettcher
Public Health Sanitarian 3
St. Paul, MN / Freeman
651-201-5076
john.boettcher@state.mn.us