Electronically Delivered

November 18, 2024

Licensee
We Care Residential Inc.
1094 17th Avenue Southeast
Minneapolis, MN 55414

RE: Project Number(s) SL40150015

Dear Licensee:

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

The Minnesota Department of Health completed an initial survey on October 15, 2024, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

The Department of Health concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. The Department of Health documents state correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

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

DOCUMENTATION OF ACTION TO COMPLY

Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the

correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

Renee Anderson, Supervisor
State Evaluation Team
Email: renee.anderson@state.mn.us
Telephone: 651-201-5871 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40150	A. BUILDING: _____ B. WING _____	10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WE CARE RESIDENTIAL INC	1094 17TH AVENUE SOUTHEAST MINNEAPOLIS, MN 55414

(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: SL40150015-0 On October 14, 2024, through October 15, 2024, 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 was one (1) resident whom received services under the provider's Provisional Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 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 document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated October 14, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements:	0 680		

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0 680	Continued From page 2 (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 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 have a written emergency disaster plan with all required content that was reviewed/updated annually.This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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).	0 680		

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0 680	Continued From page 3 The findings include: The licensee's Emergency Preparedness (EP) plan, dated 2022, had not been reviewed/updated annually, and lacked the following required content: -current, all-hazards approach facility assessment; -development of all policies/procedures, based on assessment; and additional policies for: -handling and use of volunteers; -arrangement with other facilities (including sister facilities); -development of emergency officials and contact information; -development of a communication plan, including primary and alternate means for communication; -EP training and testing program; -EP training program for staff (including documentation of training provided); and -annual EP testing requirements. On October 14, 2024, at 1:33 p.m., clinical nurse supervisor (CNS)-B stated the original license expired in 2022, due to lack of residents within a one-year period, and facility was subsequently closed. CNS-B stated facility was reopened in 2023, and their first resident admitted in 2024, therefore, licensee's EP plan had not been completed or reviewed since 2022. The licensee's Emergency Preparedness policy, dated January 2, 2023, indicated the licensee would have an identified plan in place that would assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services, as referenced in the Center for Medicare Service (CMS) State Operations Manual Appendix Z. Furthermore, the	0 680		

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0 680	Continued From page 4 EP plan would include the following: -current, all-hazards approach facility assessment; -development of all policies/procedures, based on assessment; and additional policies for: -handling and use of volunteers; -arrangement with other facilities (including sister facilities); -development of emergency officials and contact information; -development of a communication plan, including primary and alternate means for communication; -EP training and testing program; -EP training program for staff (including documentation of training provided); and -annual EP testing requirements. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 790 SS=E	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and	0 790		

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0 790	Continued From page 5 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to install a portable fire extinguisher as required by statute. This deficient condition had the potential to affect a limited number of 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On October 15, 2024, at 2:15 p.m., survey staff toured the facility with unlicensed personnel (ULP)-C. During the tour, the surveyor observed a portable fire extinguisher was stored in a cabinet under the kitchen sink. Fire extinguishers must be available in an emergency and properly mounted to prevent them from being moved or damaged. Fire extinguishers need to be located along normal paths of travel in a visible location. During the facility tour interview on October 15, 2024, ULP-C verified this fire extinguisher was not properly installed. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=D	144G.45 Subd. 2 (a) (4) Fire protection and physical environment	0 800		

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0 800	Continued From page 6 (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 provide 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 a limited number of 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 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 October 15, 2024, at 2:15 p.m., survey staff toured the facility with unlicensed personnel (ULP)-C. During the tour, the surveyor observed the following: - The smoke alarm was covered with plastic film in occupied resident sleeping room 2 on the main level. Smoke alarms must be installed and maintained according to the manufacturer's instructions. - Extension cords were used to supply power in	0 800		

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0 800	Continued From page 7 two unoccupied lower level resident sleeping rooms. During the facility tour interview on October 15, 2024, ULP-C verified the above listed observations. TIME PERIOD FOR CORRECTION: Two (2) 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 8 (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, interview, and record review, the licensee failed to develop a fire safety and evacuation plan (FSEP) with the required content. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 15, 2024, at 2:15 p.m., survey staff toured the facility with unlicensed personnel (ULP)-C. During the tour of the lower level, the surveyor observed the resident sleeping room numbers posted on the doors did not match the number labels on the posted FSEP floor plan dated October 14, 2021. Resident sleeping room identifiers must correspond with the labels on the fire safety and evacuation floor plan to provide efficient communication for exiting in the event of a fire or similar emergency. During the facility tour interview on October 15, 2024, ULP-C verified the FSEP floor plan did not accurately identify the	0 810		

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0 810	Continued From page 9 location of resident sleeping rooms. On October 15, 2024, ULP-C provided documents on the FSEP, fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee failed to develop and maintain a FSEP evident by a record review of the available documentation. The FSEP included a fire safety policy dated January 2, 2023. This fire safety policy was a template from a third-party provider and not developed for use at this facility location. 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 FSEP included the RACE (Remove, Alarm, Confine and Extinguish or Evacuate) acronym and the fire safety procedure instructed staff to pull the nearest fire alarm in case of fire, but the facility did not have a fire alarm system. The FSEP also instructed staff to close all doors to contain the fire, but the facility did not have a fire rated door and wall assembly. The FSEP fire safety policy did not identify specific fire protection procedures necessary for residents evident by limited instructions directing residents to stoop or crawl to avoid smoke. The licensee failed to provide specific procedures for resident movement and evacuation during a fire or similar emergency including individualized unique needs of residents in the FSEP.	0 810		

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0 810	Continued From page 10 The FSEP fire safety policy directed employees to evacuate residents from the building but failed to include information on where residents should relocate to in the event of a fire. The FSEP floor plan dated October 14, 2021, did not accurately identify the location of the installed portable fire extinguishers. During an interview on October 15, 2024, at 3:15 p.m., ULP-C verified the FSEP required revision. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 970 SS=F	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for resident health, safety, or personal property. This had the potential to affect all residents. 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	0 970		

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0 970	Continued From page 11 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: R1's lease agreement, dated July 1, 2024, a part of R1's assisted living contract, included the following statement, indicating a waiver of liability: "[Provider] is not liable to [Resident] or [Resident's] guests for any injury, death or property damage occurring in the Apartment Unit or on [Provider's] premises unless such injury, death or property damage occurrs as the result of an equipment malfunction or hazardous conditions within the building, not caused by [Resident] or [Resident's] guests. [Provider] is also not liable for any injury, death, or damage occurring as the result of [Resident's] receipt of health-related, supportive or other services from third-party providers. [Provider] may be liable to [Resident] for it's own negligent acts or those of it's employees or agents. Unless caused by one of the aforementioned excepted reasons, [Resident] agrees to hold [Provider] harmless from any and all claims for injuries, property damage or any other loss resulting from an accident or other occurrence in the Apartment Unit or on [Provider's] premises." On October 14, 2024, at 1:00 p.m., clinical nurse supervisor (CNS)-B stated the licensee's assisted living contract, lease agreement section, included the above content, and stated the same contract was utilized for all residents at the facility. CNS-B further stated, the licensee had been utilizing contract and lease agreement documents licensee purchased from a consulting company.	0 970		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 970	Continued From page 12 The licensee's Assisted Living Contract policy dated January 2, 2024, indicated licensee's assisted living contract was a written agreement between the facility and the resident, outlining the terms of housing and assisted living services, and would include terms regarding housing, and details of assisted living services provided, whether directly or through agreements. Furthermore, the contract would not include waivers of liability for the facility concerning resident health, safety, or personal property. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
03090 SS=F	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 the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all current residents in the assisted living facility, staff, and any visitors of the licensee.	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40150	A. BUILDING: _____ B. WING _____	10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WE CARE RESIDENTIAL INC	1094 17TH AVENUE SOUTHEAST MINNEAPOLIS, MN 55414

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03090	Continued From page 13 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 finding include: On October 14, 2024, at 10:10 a.m. upon arriving at the establishment, the outside front entrance and just inside the front entrance were observed to lack the required posting for electronic monitoring devices. On October 14, 2024, at 10:50 a.m., during a facility tour with licensed assisted living director (LALD)-B, there was no sign posted in the main entry way of the establishment regarding electronic monitoring. LALD-B stated licensee had a sign in the front hallway closet but had not placed it at the main entry of the facility. On October 14, 2024, at 10:55 a.m., owner (O)-A handed surveyor metal signage which read "Warning 24-Hour Video Surveillance, No Trespassing" and stated that was the sign licensee would need to post. The sign lacked the required verbiage. The licensee's Electronic Monitoring policy dated January 2, 2023, indicated, signs would be posted at each facility entrance accessible to visitors that stated: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons or activities."	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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03090	Continued From page 14 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090		

DEPARTMENT OF HEALTH

Environmental Health
Food, Pools, and Lodging
625 Robert St. N
St. Paul
651-201-5000

Type: Full
Date: *10/14/24*
Time: 11:00:00
Report: 1031241294

Food and Beverage Establishment Inspection Report

Location:
WE CARE RESIDENTIAL INC
1094 17TH AVENUE SOUTHEAST
Minneapolis, MN55414
Hennepin County, 27

Establishment Info:
ID #: 0043706
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/24

Operator:

Phone #:
ID #:

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

The following orders were issued during this inspection.

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) ***** Priority 1 *****

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

RAW EGGS STORED ON SHELF ABOVE FRUIT.

HAS STAFF MOVE EGGS DOWN AND FRUIT UP.

Corrected on Site

7-200 Toxic Supplies and Applications

7-204.11 ***** Priority 1 *****

MN Rule 4626.1620 Discontinue using chemical sanitizers, including chemical sanitizing solutions generated on site and other chemical antimicrobials on food-contact surfaces that do not meet the requirements specified in 40 CFR part 180, section 180.940, or part 180, subpart E, section 180.2020.

LYSOL SPRAY USED FOR FOOD CONTACT SURFACES MEASURED > 400 PPM. HAS STAFF MAKE BLEACH AND WATER SPRAY.

DISCONTINUE USING PREMADE SPRAY CHEMICALS ON FOOD CONTACT SURFACES.

MAKE BLEACH AND WATER SPRAY, TEST FOR CONCENTRATION, AND USE DAILY.

Corrected on Site

4-300 Equipment Numbers and Capacities

4-302.12B ***** Priority 2 *****

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

ESTABLISHMENT DOES NOT HAVE A THIN PROBE THERMOMETER. EXAMPLES SENT WITH REPORT.

Comply By: 10/17/24

4-300 Equipment Numbers and Capacities

4-302.13B ***** Priority 2 *****

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

ESTABLISHMENT MISSING IRREVERSIBLE MEASURING DEVICE. PROVIDE IRREVERSIBLE MEASURING AND MEASURE UTENSIL TEMPERATURE (160F REQUIRED) AT REGULAR INTERVALS.

Comply By: 10/17/24

4-300 Equipment Numbers and Capacities

4-302.14 ***** Priority 2 *****

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

ESTABLISHMENT DOES NOT HAVE SANITIZER TESTING KIT ON SITE. PURCHASE KIT AND TEST SANI CONCENTRATION (50-200PPM BLEACH, 150-400PPM QUAT)

Comply By: 10/17/24

6-300 Physical Facility Numbers and Capacities

6-301.12 ***** Priority 2 *****

MN Rule 4626.1445 Provide and maintain a supply of individual disposable towels, a continuous towel system, a heated-air hand drying device, or an approved ambient air temperature hand drying device at each handwashing sink or group of adjacent handwashing sinks.

EMPLOYEE BATHROOM MISSING PAPER TOWELS.

Comply By: 10/16/24

2-100 Supervision

2-102.12AMN

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

ESTABLISHMENT DOES NOT HAVE A CERTIFIED FOOD PROTECTION MANAGER (CFPM).

Comply By: 10/14/24

3-500A Microbial Control: cooling

3-501.13ABC

MN Rule 4626.0380ABC Thaw TCS food by one of the following methods: 1. under mechanical refrigeration that maintains the food temperature at 41 degrees F (4 degrees C) or less; 2. completely submerged under running water at 70 degrees F (21 degrees C) or less with a velocity to remove loose particles on an overflow and the food is maintained at 41 degrees F (5 degrees C) or less; 3. in a microwave oven or; 4. as part of the cooking process.

STAFF USING SETTING FOODS ON COUNTER OR USING HOT WATER TO THAW.

DISCONTINUE BOTH PRACTICES.

USE ONLY THE 3 METHODS LISTED ABOVE TO THAW.
Comply By: 10/14/24

4-500 Equipment Maintenance and Operation

4-501.11AB

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

LIGHTS ARE BURNT OUT IN REFRIGERATOR.

REPLACE BULBS.
Comply By: 11/04/24

6-300 Physical Facility Numbers and Capacities

6-301.20

MN Rule 4626.1450 Provide a waste receptacle for individual towels at the handwashing sink where individual towels are used.

EMPLOYEE BATHROOM IS MISSING WASTE RECEPTACLE.
Comply By: 10/16/24

Surface and Equipment Sanitizers

Dimethyl Ethyl Benzyl Ammo: > 400 at Degrees Fahrenheit
Location: Lysol Spray Disinfectant
Violation Issued: No

Hot Water: = at 160 Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/Milk
Temperature: 39 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	2	4	4

Nurse Evaluator on site: Rhonda Makel

All violations discussed with PIC during the inspection.

NOTES:

- Establishment has a residential kitchen (4626.0506(G)(2)) Same-day service only. No saving and reheating of foods or preparation of foods the day prior to eating. Any remaining food from meals to be

removed/discarded at end of day.

- Staff must prepare sanitizer bucket or squirt bottle daily. Check concentration with test strips (50-200ppm Chlorine) when preparing solution.

- Establishment does not have pasteurized eggs and does not prepare eggs for consumption under 145F. Purchase pasteurized eggs if intending to serve eggs undercooked.

- Make sure to datemark any prepared cold items that are kept in refrigerator.

- Cutting boards are being utilized as food contact surfaces and not counters or plates.

- Establishment needs to check dish washer utensil temperature weekly (160F required). If utensil temp not reaching 160F, use washer to wash/rinse and sink basin with sanitizer solution to sanitize dishes then air dry, as discussed during inspection.

- 2-Comp sink has left basin designated for handwashing and the right basin for product washing/prep sink.

- When preparing food, make sure to use a thin-probe thermometer to check temperatures.

- When temping refrigerator, use thin probe thermometer in a food product.

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Environmental Health inspection report number 1031241294 of 10/14/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/__/_____

Inspection report reviewed with person in charge and emailed.

Signed:_____

Adnan Mohammed
Person in Charge on Oct 14

Signed:_____

Chris Foster
Public Health Sanitarian II
Freeman Office Building
651-983-8760
chris.j.foster@state.mn.us