



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

January 3, 2025

Licensee

Primus Incorporated

7756 Dupont Avenue North

Brooklyn Park, MN 55444

RE: Project Number(s) SL34274016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 4, 2024, 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.

MDH 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. 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 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 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>

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 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: 34274	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/04/2024
NAME OF PROVIDER OR SUPPLIER PRIMUS INCORPORATED		STREET ADDRESS, CITY, STATE, ZIP CODE 7756 DUPONT AVENUE NORTH BROOKLYN PARK, MN 55444			
(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: SL34274016-0 On December 2, 2024 through December 4, 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 were two residents; two receiving services under the provider's 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 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480			

Minnesota Department of Health

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

TITLE

(X6) DATE

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0 480	Continued From page 1 (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 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	0 480			

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0 480	Continued From page 2 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 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 December 2, 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			

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0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included baseline testing for one of three employees (unlicensed personnel (ULP)-D). 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).	0 660			

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0 660	Continued From page 4 The findings include: The facility TB risk assessment dated February 24, 2024, indicated the facility was a low risk setting for TB transmission. ULP-D was hired February 1, 2024, and provided direct care and services for residents of the facility. ULP-D's employee record included a TB history and symptom screening form completed, February 1, 2024, and a QuantiFERON-TB Gold (blood test) dated September 29, 2023, which was greater than 90-days prior to employment start date. The record further included documentation of a skin test initiated January 1, 2024, however, the document lacked a reading of the skin test within 72 hours, as required. On December 3, 2024, at 11:43 a.m., licensed assisted living director (LALD)-A stated ULP-D's employee record lacked documentation of baseline TB testing at time of hire. LALD-A indicated they had not followed-up with ULP-D's TB result documentation. The Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013 noted training was required at the time of hire and included: pathogenesis, signs symptoms, and the licensee's infection control plan. In addition, baseline screening for all health care workers (HCW) included a history and symptom screen and testing for the presence of TB infection. The regulations noted a blood test should include the date of the test. According to the regulations, if a HCW had documentation for latent TB, that documentation could be substituted for documentation of a previous positive TST or	0 660			

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0 660	Continued From page 5 blood test. The licensee's Tuberculosis Screening policy, dated August 1, 2022, indicated the licensee would establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the CDC, Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report (MMWR). Furthermore, the policy indicated screening would be conducted as follows: 1. New staff will be screened for active signs of TB using the Baseline TB Screening Tool for HCWs. 2. New staff will have an IGRA blood test or a two-step Mantoux conducted with results documented on the Baseline TB Screening Tool for HCWs. 3. No staff will be permitted to begin work where the work involves sharing the air space with residents until the negative results of the first Mantoux are read and documented or a negative IGRA blood test result is received and documented. 4. Staff TB screening results will be kept in each employee medical file. 5. Staff should be screened for signs and symptoms on an annual basis. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with	0 780			

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0 780	Continued From page 6 the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that functioned and were interconnected so that the actuation of one alarm caused all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and 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 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 780			

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0 780	Continued From page 7 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 December 4, 2024, from 11:15 a.m. to 12:30 p.m., the surveyor toured the facility with housing manager (HM)-B. The surveyor asked HM-B to initiate a test of the smoke alarms throughout the home. Upon testing, it was found that the smoke alarm in the hallway outside bedrooms 1 and 2 was not interconnected with the rest of the smoke alarms in the facility. On December 4, 2024, at 1:30 p.m., HM-B stated they were not aware that the hallway smoke alarm was not interconnected with the rest. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780			
0 800 SS=D	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced	0 800			

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0 800	Continued From page 8 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 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 December 4, 2024, from 11:15 a.m. to 12:30 p.m., the surveyor toured the facility with housing manager (HM)-B. The following was observed: There was an electrical light fixture cover missing on the ceiling in the upper level hallway. Electrical light fixtures are required to be maintained with all covers in place in accordance with the manufacture's installation instructions. The office in the basement was missing the trim around the door inside and outside the office and the baseboard at the floor to wall transitions were not installed leaving the unfinished construction materials exposed to the room. On December 4, 2024, at 1:30 p.m., HM-B stated the office had been built a few years ago and they	0 800			

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0 800	Continued From page 9 had not gotten around to finishing the trim work. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) 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) 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 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	0 810			

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0 810	Continued From page 10 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 the fire safety and evacuation plan with the required content and to provide the required training and to conduct evacuation drills. 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 December 4, 2024, housing manager (HM)-B and licensed assisted living director (LALD)-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 policy, titled "Emergency Preparedness Plan", undated, failed to include the following: The Emergency Preparedness Plan did not include a section specific to fire safety and evacuation. On December 4, 2024, at 1:30 p.m., LALD-A	0 810			

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0 810	Continued From page 11 stated they were in the process of transferring all their policies to an online platform and did not realize the fire safety and evacuation plans were not completed. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. LALD-A lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. LALD-A lacked documentation showing any training was offered or training was scheduled for a future date for employees on the fire safety and evacuation plan. On December 4, 2024, at 1:30 p.m., LALD-A stated they provided training on the fire safety and evacuation plan at their bi-monthly staff meetings but did not have any documentation. 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, titled "Fire Drills", undated, indicated evacuation drills were conducted monthly in 2024. LALD-A lacked documentation for any evacuation drills completed in 2023. On December 4, 2024, at 1:30 p.m., LALD-A stated there were no additional documented drills for the facility. TIME PERIOD FOR CORRECTION: Twenty-one	0 810			

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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
0 810	Continued From page 12 (21) days	0 810			
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a background study was submitted and received for two of three employees (unlicensed personnel (ULP)-C, ULP-D). 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).	01290			

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01290	Continued From page 13 The findings include: On December 2, 2024, at 10:32 a.m., the surveyor observed ULP-C administer oral medications to R1. ULP-C was hired February 29, 2020, to provide direct care and services to the licensee's residents under the comprehensive license. ULP-C began providing services under the licensee's assisted living license on August 1, 2021. ULP-C's employee record included a background study clearance letter, dated February 10, 2020. The background study was affiliated with health facility identification number (HFID) 32478, which was also owned by the licensee. ULP-C's employee record lacked evidence the licensee submitted a background study affiliated with the licensee's HFID, 34274. ULP-D was hired February 1, 2024, to provide direct care and services to the licensee's residents. ULP-D's employee record contained a background study clearance letter, dated January 22, 2024. The background study was affiliated with HFID 32915 also owned by the licensee. ULP-D's employee record lacked evidence the licensee submitted a background study affiliated with the licensee's HFID, 34274. On December 3, 2024, at 10:35 a.m., housing manager (HM)-B stated the staff share work locations and most only had background studies run under one location, HFID 32915 which was a sister facility.	01290			

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NAME OF PROVIDER OR SUPPLIER PRIMUS INCORPORATED			STREET ADDRESS, CITY, STATE, ZIP CODE 7756 DUPONT AVENUE NORTH BROOKLYN PARK, MN 55444		
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01290	Continued From page 14 On December 3, 2024, at 1:50 p.m., licensed assisted living director (LALD)-A stated the licensee was not aware the background check needed to be affiliated with each HFID the employees had been working in. LALD-A further stated she and HM-B were Sensitive Information Person's (SIP's) for all locations, and had been in contact with Department of Human Services (DHS) so employees would have background studies affiliated with each location. The licensee's Background Studies policy dated August 1, 2021, indicated the licensee would conduct a DHS background study of all employees, volunteers, and contractors, and no employee would provide direct services or have direct contact with any residents until acceptable results of the background study had been received. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290			
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 and interview, the licensee	03090			

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NAME OF PROVIDER OR SUPPLIER PRIMUS INCORPORATED		STREET ADDRESS, CITY, STATE, ZIP CODE 7756 DUPONT AVENUE NORTH BROOKLYN PARK, MN 55444			
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03090	Continued From page 15 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. This had the potential to affect all current residents in the assisted living facility, staff, and any visitors of the licensee. 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: Upon entrance on December 2, 2024, at 10:05 a.m., an observation outside the front entrance showed no required posting for electronic monitoring devices, and just inside the front entrance hallway, a sign displayed the language "Warning Camera in Use." On December 2, 2024, at 10:30 a.m., during a self-guided facility tour of the establishment, licensee lacked a posted sign at each facility entrance, accessible to visitors that stated, "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." On December 2, 2024, at 11:33 a.m., licensed assisted living director (LALD)-A stated licensee lacked a required posting at front entrance to facility with the statutory language noted above. LALD-A further stated she was not aware of the required statutory language and thought the "Camera in Use" signage located on the front	03090			

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03090	Continued From page 16 hallway wall was sufficient enough to meet the requirement. Licensee's Electric Monitoring policy dated August 1, 2021, indicated signs would be posted at each facility entrance accessible to visitors that state: ""Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." Furthermore, staff would not knowingly hamper, obstruct, tamper with, or destroy a resident's electronic monitoring device installed as permitted under 144.6502. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	03090			

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Food and Beverage Establishment Inspection Report

Page 1

Location:

Primus Incorporated
7756 Dupont Avenue North
Brooklyn Park, MN 55444
Hennepin County, 27

Establishment Info:

ID #: 0038818
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7637323729
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.

2-200 Employee Health

2-201.11C

**** Priority 1 ****

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.

NO EMPLOYEE ILLNESS LOG ON SITE. DISCUSSED EXCLUSION AND RECORDING REQUIREMENTS, AND LEFT BLANK LOG ON SITE.

Comply By: 12/02/24

3-500C Microbial Control: date marking

3-501.17B

**** Priority 2 ****

MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened 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. The date must not exceed the manufacturer's use-by-date.

OPENED CONTAINERS OF MILK AND LETTUCE WERE NOT DATE MARKED. DISCUSSED REQUIREMENTS TO MARK TCS FOODS WITH THE DATE THEY ARE OPENED AND THEN USE OR DISCARD WITHIN 7 DAYS. FACT SHEET LEFT ON SITE.

Comply By: 12/02/24

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.

THERE IS NO DEVICE ON SITE TO MEASURE THE UTENSIL SURFACE TEMPERATURE IN

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THE DISHWASHER. PROVIDE TEMPERATURE STRIPS OR A MAXIMUM REGISTERING THERMOMETER TO VERIFY THAT THE UTENSIL SURFACE TEMPERATURE IS 160 DEGREES F OR ABOVE.
Comply By: 12/09/24

Surface and Equipment Sanitizers

Utensil Surface Temp.: = at 160+ Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/AMBIENT
Temperature: 37 Degrees Fahrenheit - Location: LARGE KITCHEN REFRIGERATOR
Violation Issued: No

Process/Item: Cold Hold/CREAM CHEESE
Temperature: 41 Degrees Fahrenheit - Location: LEFT "THOMSON" REFRIGERATOR
Violation Issued: No

Process/Item: Cold Hold/HOT DOG
Temperature: 41 Degrees Fahrenheit - Location: LEFT "THOMSON" REFRIGERATOR
Violation Issued: No

Process/Item: Cold Hold/MILK
Temperature: 36 Degrees Fahrenheit - Location: RIGHT "THOMSON" REFRIGERATOR
Violation Issued: No

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

INSPECTION COMPLETED WITH DIRECTOR AND REVIEWED WITH HRD NURSING EVALUATOR RHONDA MAKELA.

INSPECTOR LEFT A THERMOLABEL ON SITE AND AFTER INSPECTION OPERATOR SENT INSPECTOR A PICTURE OF THE TEMPERATURE STRIP THEY RAN THROUGH THEIR DISHWASHER, WHICH SHOWED IT PROVIDED A UTENSIL SURFACE TEMPERATURE OF 160+ DEGREES F.

DISCUSSED DATE MARKING, GLOVE USE, COOKING TEMPERATURES, CROSS-CONTAMINATION, AND EMPLOYEE ILLNESS.

KITCHEN IS RESIDENTIAL AND FOOD IS PREPARED FOR SAME DAY SERVICE.

FLOORING IS LAMINATE, CABINETS ARE WOOD WITH HOLLOW BASE, COUNTERS ARE LAMINATE, AND THE CEILING HAS A POPCORN FINISH. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

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Food and Beverage Establishment Inspection Report

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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 1005241314 of 12/02/24.

Certified Food Protection Manager: TAIWO R. OBAZELUBLA

Certification Number: FM109101 Expires: 12/21/27

Inspection report reviewed with person in charge and emailed.

Signed: _____

SAMUEL AFOLAYAN
DIRECTOR

Signed: _____



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