



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

May 16, 2024

Licensee

Living Hope Homes - Brent House

5039 Brent Avenue

Inver Grove Heights, MN 55076

RE: Project Number(s) SL37945016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a SL37945016 on May 2, 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,



Jess Schoenecker, Supervisor

State Evaluation Team

Email: jess.schoenecker@state.mn.us

Telephone: 651-201-3789 Fax: 1-866-890-9290

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37945	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/02/2024
NAME OF PROVIDER OR SUPPLIER WE CARE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 5039 BRENT AVENUE INVER GROVE HEIGHTS, MN 55076			
(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, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#37945016 On April 29, 2024, through May 2, 2024, 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 4 residents; 4 receiving services under the 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.		
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required	0 110			

Minnesota Department of Health

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

TITLE

(X6) DATE

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record for the licensee through the Board of Executives for Long-Term Service and Supports (BELTSS) website. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: LALD/clinical nurse supervisor (CNS)-A was licensed on December 20, 2021. On April 29, 2024, at 11:30 a.m., during the entrance conference, LALD/CNS-A stated they were not aware they were required to identify themselves as the Director of Record on the BELTSS website. LALD/CNS-A stated would log into the BELTSS website to identify themselves as the Director of Record. The BELTSS website accessed on April 24, 2024, at 9:54 a.m., indicated LALD/CNS-A was licensed	0 110			

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0 110	Continued From page 2 but was not listed as the Director of Record for the licensee. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110			
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (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 April 30, 2024, for the specific Minnesota Food Code violations. The Inspection	0 480			

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0 480	Continued From page 3 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			
0 570 SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to display the original current license at the main entrance as required. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: On April 29, 2024, at approximately 10:00 a.m., upon entering the facility, the surveyor noted the license was not posted at the facility entrance as required. On April 29, 2024, at approximately 10:15 a.m., during the facility tour with unlicensed personnel (ULP)-B, the surveyor observed the license was not posted in the facility.	0 570			

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0 570	Continued From page 4 On April 29, 2024, at 12:10 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the license used to be posted but the frame broke, and now was stored in the office. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 570			
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop an individual abuse prevention plan (IAPP) with the required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to	0 630			

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0 630	Continued From page 5 cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the clients). The findings include: R1 was admitted on September 1, 2023. R1's IAPP dated September 17, 2023, indicated R1 is at risk to be abused by another individual, including other vulnerable adults but lacked statements of specific measures to be taken to minimize the risk of abuse to R1 from others. On April 29, 2024, at 2:45 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A confirmed R1's IAPP did not include statements of specific measures to be taken to minimize risks. LALD/CNS-A stated was not aware of all the required contents of the IAPP. The licensee's 2.44 Vulnerable Adult Maltreatment - Prevention & Reporting policy dated September 1, 2023, indicated the licensee developed individualized vulnerable adult abuse prevention plans to identify risks and develop measures to minimize maltreatment based on identified information. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control	0 660			

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0 660	Continued From page 6 (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 observation, 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 a history screening and testing result for one of one employee (unlicensed personnel (ULP)-B). 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:	0 660			

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0 660	Continued From page 7 The licensee's TB risk assessment dated October 24, 2023, indicated the facility was at low risk for TB transmission. ULP-B began employment with the licensee on September 1, 2023. ULP-B's employee record lacked documented evidence of required Baseline Screening Tool for Healthcare Personnel and required TB testing by blood test or tuberculin skin testing. On April 29, 2024, at approximately 1:00 p.m., the surveyor observed ULP-B perform medication administration on R1. On April 29, 2024, at 2:00 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated ULP-B's TB history screening and testing was not performed at time of hire and was unsure why. The licensee's 8.16 Tuberculosis Screening policy dated September 1, 2023, indicated each staff person at time of hire and prior to any contact with residents would be screened and tested for TB. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and the CDC guidelines, indicated a TB infection control program should include a facility TB risk assessment. The guidelines also indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW	0 660			

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0 660	Continued From page 8 (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
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 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	0 680			

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0 680	Continued From page 9 by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all visitors, employees, 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On April 29, 2024, at approximately 12:00 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A provided a binder and indicated the contents were the licensee's EPP. The licensee's EPP undated, lacked an individualized plan to include all the required content below: -missing annual review; -missing resident quarterly review; -description of the population served by licensee; -process for EP cooperation with state and local EP officials/organizations; -development of all policies/procedures (P/P) based on HVA assessment; -development of a communication plan; and -EP training and testing program. On April 29, 2024, at approximately 12:45 p.m., LALD/CNS-A acknowledged the licensee's EPP lacked the above listed required content.	0 680			

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0 680	Continued From page 10 LALD/CNS-A stated the licensee's EPP was a work in progress and was not aware of all the requirements of Appendix Z. The licensee's 9.01 Emergency Preparedness Plan - Appendix Z policy dated September 1, 2023, indicated the licensee would have an identified EPP in place and will include all the required elements of Appendix Z. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680			
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (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	01620			

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01620	Continued From page 11 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 a registered nurse (RN) completed comprehensive assessments to include all required content identified per Minnesota Administrative Rule 4659.0150 Uniform Assessment Tool 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 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: R1 was admitted on September 1, 2023. R1's Nurse Reassessment Visit record dated February 25, 2024, was a two-page document identified by licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A as R1's 90-day RN assessment completed by LALD/CNS-A. The assessment was marked in multiple areas with a check that read "no change" (NC) and lacked any data in those areas about R1's physical or cognitive assessment completed by LALD/CNS-A. R1's assessments lacked the required content for	01620			

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NAME OF PROVIDER OR SUPPLIER WE CARE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 5039 BRENT AVENUE INVER GROVE HEIGHTS, MN 55076			
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01620	Continued From page 12 the Uniform Assessment Tool. On April 29, 2024, at 3:00 p.m., LALD/CNS-A stated licensee was not aware of the required content from the Uniform Assessment Tool as required in Minnesota Administrative Rule 4659.0150 and had been using the same 90-day assessment record for all residents that was acquired from LALD/CNS-A's previous employment in home care. LALD/CNS-A also stated licensee had recently purchased a new electronic health record system (RTasks) and was in the process of converting from paper charts to electronic charts. LALD/CNS-A stated the new system would include the required content on all assessments. The licensee's 6.01 Assessments, Reviews & Monitoring policy dated September 1, 2023, indicated the nursing reassessment would include all the elements of the uniform assessment tool as required. Minnesota Administrative Rule 4659.0150 dated August 11, 2021, identified all required areas of the Uniform Assessment Tool. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620			

Type: Full
Date: 04/30/24
Time: 12:14:54
Report: 1036241081

Food and Beverage Establishment Inspection Report

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Location:

We Care Assisted Living
5039 Brent Avenue
Inver Grove Heights, MN55076
Dakota County, 19

Establishment Info:

ID #: 0037550
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6514247163
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. EXAMPLE MDH ILLNESS LOG SENT TO ESTABLISHMENT ALONG WITH REPORT.

Comply By: 05/01/24

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.

OBSERVED EGGS STORED ABOVE RTE FOODS IN THE FRIDGE. CARTON OF EGGS WAS MOVED TO BOTTOM DRAWER. ISSUE CORRECTED ON SITE.

Comply By: 04/30/24

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

3-305.11A

MN Rule 4626.0300A Store all food in a clean, dry location; where it is not exposed to splash, dust or other contamination; and at least 6 inches above the floor.

OBSERVED FOOD BOXES/CONTAINERS BEING STORED DIRECTLY ON THE FLOOR IN THE DRY STORAGE ROOM. COMPLY WITH ABOVE RULE.

Comply By: 05/21/24

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Surface and Equipment Sanitizers

UTENSIL SURFACE TEMP: = at 170 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Ambient Temp
Temperature: 39 Degrees Fahrenheit - Location: FRIDGE
Violation Issued: No

Process/Item: Ambient Temp
Temperature: 0 Degrees Fahrenheit - Location: FREEZER
Violation Issued: No

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

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. SURVEYOR FROM HRD WAS CARL SAMROCK. INSPECTION CONDUCTED IN PRESENCE OF TAWANA HENDERSON, THE PERSON IN CHARGE. AT TIME OF INSPECTION, ESTABLISHMENT HAD 4 RESIDENTS. MAJORITY OF FOOD IS PURCHASED AT LOCAL COSTCO. ALL VIOLATIONS WERE DISCUSSED WITH THE PERSON IN CHARGE DURING INSPECTION.

THIS FACILITY DOES NOT HAVE COMMERCIAL GRADE ANSI EQUIPMENT. ALL FOOD MUST BE SERVED THE SAME DAY IT IS PREPARED, AND LEFTOVERS CAN NEVER BE SAVED.

DISCUSSED ALL ORDERS ON SITE IN ADDITION TO THE FOLLOWING WITH KITCHEN STAFF:

- EMPLOYEE ILLNESS LOG AND EXCLUSION POLICY.
- HAND WASHING POLICY AND REVIEW.
- PROPER FOOD STORAGE.
- GLOVE USAGE.
- THERMOMETER USE AND CALIBRATION.
- DATE MARKING.
- PEST CONTROL.
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS.
- ANSI 184 STANDARD FOR RESIDENTIAL DISH WASHER.

FOR CORRECT BY DATES REFER TO COMPLETE REPORT ISSUED BY HRD.

**IF ANY RESIDENT COMPLAINS OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE CUSTOMER. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.

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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 inspection report number 1036241081 of 04/30/24.

Certified Food Protection Manager: MAYDEU LY

Certification Number: FM119050 Expires: 09/27/26

Inspection report reviewed with person in charge and emailed.

Signed: _____

TAWANA HENDERSON
PERSON IN CHARGE

Signed: _____

Jeff Johanson