Electronically Delivered

January 9, 2024

Licensee
Greatercare Facilities, LLC
7780 Somerset Road
Woodbury, MN 55125

RE: Project Number(s) SL37679015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 21, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

The correction order documentation should include the following:

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

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

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

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,

Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37679	A. BUILDING: _____ B. WING _____	12/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREATERCARE FACILITIES LLC	7780 SOMERSET ROAD WOODBURY, MN 55125

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL37679015-0 On December 19, 2023, through December 21, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were two residents; both received services under the Assisted Living license. An immediate correction order was identified on December 19, 2023, issued for SL37679015-0, tag identification 1290. On December 21, 2023, the immediacy of correction order 1290 was removed, however non-compliance remained, and the scope and level remained unchanged.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	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 December 18, 2023, 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: (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	0 680		

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0 680	Continued From page 2 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 observation, 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 residents receiving services under the assisted living license. 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:	0 680		

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0 680	Continued From page 3 The licensee's Assisted Living Emergency Preparedness Manual (EPP), updated August 1, 2021, lacked the following required content: - EP policies/procedures review/updated annually; - P/P to address system of medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records; - P/P to address role of facility under a waiver declared by the Secretary in accordance with section 1135 of the Act; - means to providing information about the facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee On December 19, 2023, at approximately 10:30 a.m., licensed assisted living director (LALD)-A stated that they utilize the same EPP across all affiliated facilities, and had received citations at their affiliated facilities during previous surveys. LALD-A stated that they have been unable to update all EPP manuals and were aware that the document contained deficiencies. The licensee's 9.01 Emergency Preparedness Plan-Appendix Z Compliance dated August 1, 2021, indicated the emergency preparedness plan would include all required element of appendix Z and reviewed annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		

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0 790	Continued From page 4	0 790		
0 790 SS=F	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 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers as required by statute. This deficient condition 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 of the residents). The findings include: On December 19, 2023, at 11:11 a.m., survey staff toured the home with clinical nurse supervisor (CNS)-B. During the tour, survey staff observed monthly inspections had not been	0 790		

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0 790	Continued From page 5 recorded on the back of the tags attached to the fire extinguishers in the basement and sub-basement. During the facility tour on December 19, 2023, CNS-B confirmed the lack of monthly fire extinguisher inspections. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to 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 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	0 800		

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0 800	Continued From page 6 of the residents). The findings include: On December 19, 2023, at 11:11 a.m., survey staff toured the home with clinical nurse supervisor (CNS)-B. During the tour, survey staff observed the following: 1. The foundation of the home was starting to deteriorate on the west side of the building. Horizontal cracks and crumbling concrete were observed in the foundation and the inner cavities of the cement blocks were visible. This deterioration of the foundation could affect the structural integrity of the building. 2. Wood siding was water-damaged and starting to decay above the concrete landing near the entrance of the home on the south side of the building. 3. Rain gutters were filled with leaves and pine needles above the front entrance to the home on the south side of the building. Gutters that are clogged with debris will not properly direct roof water away from the home. 4. An exit sign was posted over the door leading into the garage from the home. This door was also labeled as an emergency exit on the floor plans. Emergency exits are required to lead directly to the exterior of the building and not through a higher hazard room. During an interview with survey staff on December 20, 2023, at 1:00 p.m., licensed assisted living director (LALD)-A explained they were aware the garage should not be used as an emergency exit from a previous survey at one of	0 800		

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0 800	Continued From page 7 the other facilities. LALD-A stated they would remove the exit sign and revise the floor plans. LALD-A confirmed the additional items of disrepair of the facility made in the above observations. 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) 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. (f) Evacuation drills are required for employees	0 810		

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0 810	Continued From page 8 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 record review and interview, the licensee failed to develop a fire safety and evacuation plan with the required content, and provide required training and drills. 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 December 20, 2023, clinical nurse supervisor (CNS)-B provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and employee evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The 9.06 Fire Policy was a template and had not been developed for use at this facility. The policy included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan inappropriately referenced smoke compartment doors, fire sprinklers, doors on magnetic holders, and pull fire alarms. The employee actions for fire were limited to the	0 810		

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0 810	Continued From page 9 acronym RACE (Remove, Alarm, Confine, and Extinguish or Evacuate). The FSEP did not identify specific fire protection procedures necessary for residents evident by limited instructions directing employees to remove tenants from immediate danger by evacuating those closest to the fire and moving outwards. No additional fire protection procedures for residents were included. The FSEP directed employees to evacuate residents from the building but fails to include information on where residents should relocate to in the event of a fire. During an interview with survey staff on December 20, 2023, at 1:00 p.m., licensed assisted living director (LALD)-A confirmed the plan included inaccurate information and lacked sufficient procedures. LALD-A explained residents would relocate to the end of the driveway in the event of an evacuation and verified this was not included in the plan. TRAINING Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and/or at least twice per year as evident by the lack of training documentation. During an interview with survey staff on December 20, 2023, at 1:00 p.m., LALD-A stated fire safety and evacuation training was completed during emergency preparedness training. LALD-A further explained records had not been created to document training on the facility fire safety and evacuation plan. CNS-B explained in an email received on December 20, 2023, at 9:37 a.m., that employees were trained on fire safety and evacuation as part of the emergency preparedness training and after fire drills. Records had not been created to document training specifically for the facility's fire safety and evacuation plan.	0 810		

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0 810	Continued From page 10 Record review indicated the licensee failed to provide fire safety and evacuation training to residents at least once per year as evident by the lack of training documentation. No resident training records were provided for review. During an interview with survey staff on December 20, 2023, at 1:00 p.m., LALD-A explained residents had been trained on fire safety and evacuation, but the training had not been recorded. LALD-A stated residents participated in some of the fire drills, and this was documented on the fire drill reports. LALD-A further explained residents were provided with fire safety and evacuation information in their admission handbook. DRILLS Record review indicated the licensee failed to conduct employee evacuation drills at a frequency of twice per year per shift with at least one evacuation drill every other month as evident by a review of the completed fire drill reports. Three employee fire drills were recorded in 2022 and two employee fire drills were recorded in 2023. These five fire drills were all completed between the hours of 10:00 a.m. and 4:00 p.m. During an interview with survey staff on December 20, 2023, at 1:00 p.m., LALD-A verified the licensee had not met the evacuation drill frequency and explained that employee fire drills would be completed every other month moving forward. They further explained that the overnight shift employees completed fire drills at staff meetings, but this had not been documented. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 970 SS=F	144G.50 Subd. 5 Waivers of liability prohibited	0 970		

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0 970	Continued From page 11 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 health, safety, or personal property of a resident. 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 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: During the entrance conference on December 19, 2023, at approximately 10:15 a.m., the surveyor requested a copy of the facility's assisted living contract. The Assisted Living Agreement contract included the following language: - On page 19, section 2, Indemnification, "Resident will indemnify and hold harmless	0 970		

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0 970	Continued From page 12 Provider, its employees, and agents from and against any and all claims, actions, damages, and liability and expense in connection with loss of life, personal injury or damage to property, arising from or out of the use by Resident of the rented premises or any other part of Provider's property, or caused wholly or in part by an act or omission of Resident or Resident's guests or agents. - On page 20, section 4, 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 occurs as the result of an equipment malfunction or hazardous conditions within the building not caused by Resident or Resident's guests. On December 20, 2023, at approximately 10:30 a.m., clinical nurse supervisor (CNS)-B stated the same assisted living contract was utilized for all residents at the facility. On December 21, 2023, at approximately 11:15 a.m., during the exit conference, CNS-B stated they were unaware the current contract contained language was not in compliance with regulations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
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	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37679	A. BUILDING: _____ B. WING _____	12/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREATERCARE FACILITIES LLC	7780 SOMERSET ROAD WOODBURY, MN 55125

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01290	Continued From page 13 144.057 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 an employee 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 conducted prior to staff providing services for two of two employees (clinical nurse supervisor (CNS)-B and unlicensed personnel (ULP)-C). 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: CNS-B CNS-B began working for the licensee on April 4, 2018, and began providing assisted living services August 1, 2021. On December 19, 2023, the Minnesota Board of	01290	On December 21, 2023, the immediacy of correction order 1290 was removed, however non-compliance remained, and the scope and level remained unchanged.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01290	Continued From page 14 Nursing website indicated CNS-B obtained their Minnesota nursing licensure on February 6, 2007. On December 19, 2023, the NETStudy2.0 website (web-based system used to submit background study requests to the Department of Human Services (DHS)) roster page indicated CNS-B's background study affiliated to HFID #37679 dated July 19, 2021, was "Eligible - COVID-19 Study - Expired". On December 19, 2023, at 2:00 p.m., the surveyor observed CNS-B providing assisted living services to multiple residents. ULP-C ULP-C began working for the licensee on January 5, 2023. On December 19, 2023, the NETStudy2.0 website indicated ULP-C's background study affiliated to HFID #37679 dated December 8, 2021, was "Eligible - COVID-19 Study - Expired". On December 19, 2023, from 10:30 a.m., to 2:00 p.m., the surveyor observed ULP-C providing assisted living services to multiple residents. The licensee's weekly schedule indicated ULP-C worked independently within the facility on December 11, December 12, December 13, December 14, December 15, December 18, December 19, and was scheduled to work December 20, December 21, and December 22, 2023. On December 19, 2023, at 2:00 p.m., LALD-A stated that they were unaware of the expired background checks and would check to see if there were any active background checks at other	01290		

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01290	Continued From page 15 licensed facilities for the affected staff. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	01290		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered per physician orders for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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).	01760		

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01760	Continued From page 16 The findings include: R2's diagnoses included major depressive disorder. R2's service plan dated November 5, 2023, indicated R2 received services to include medication management. R2's provider orders dated December 18, 2023, indicated R2 received Diclofenac 1% topical gel, 2g topically four times daily. On December 20, 2023, at 7:52 a.m., the surveyor observed unlicensed personnel (ULP)-C take R2's diclofenac cream out of the medication cart and dispense an unmeasured amount into a paper medication cup for administration. The surveyor asked how this medication is measured prior to administration. ULP-C stated that the amount put into the medication cup was the amount that they were trained to administer. The surveyor then asked about using plastic dosing cards that are provided with the cream. ULP-C then disposed of the medication cup with the unmeasured amount of diclofenac cream and was observed utilizing provided dosing cards. ULP-C stated that they had been trained to use the dosing card for administration of the medication. On December 20, 2023, at 9:01 a.m., CNS-B stated that staff are trained to use dosing cards to measure the correct amount of diclofenac cream for administration. The licensee's 7.15 Medication & Treatment-Administration & Delegation policy, dated August 1, 2021, indicated the ULP would	01760		

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01760	Continued From page 17 have competently demonstrated the ability to follow the procedure for administering medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		

Minnesota Department of Health
Division of Environmental Health, FPLS
PO Box 64975
Saint Paul, 55164-0975
651-201-4500

Type: Full
Date: *12/19/23*
Time: 13:30:26
Report: 1023231252

Food and Beverage Establishment Inspection Report

Location:

Greatercare Facilities Llc
7780 Somerset Road
Woodbury, MN55125
Washington County, 82

Establishment Info:

ID #: 0039304
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6513431472
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.

OBSERVED RAW FOODS SUCH AS SHELL EGGS STORED OVER READY TO EAT FOODS. OPERATOR MOVED EGGS TO A SAFE LOCATION.

Comply By: 12/19/23

2-100 Supervision

2-102.12AMN

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

OPERATOR STATED ONE CFPM COVERS FIVE LOCATIONS. EACH LOCATION MUST HAVE A CFPM.

Comply By: 12/19/23

Surface and Equipment Sanitizers

Quaternary Ammonia: = 300PPM at Degrees Fahrenheit
Location: SANI BUCKET #1
Violation Issued: No

Quaternary Ammonia: = 300PPM at Degrees Fahrenheit
Location: SANI BUCKET #2
Violation Issued: No

Hot Water: = at 160 Degrees Fahrenheit
Location: DISH MACHINE ANSI 184
Violation Issued: No

Type: Full
Date: *12/19/23*
Time: 13:30:26
Report: 1023231252
Greatercare Facilities Llc

Food and Beverage Establishment Inspection Report

Food and Equipment Temperatures

Process/Item: Cold Hold/MILK
Temperature: 38 Degrees Fahrenheit - Location: REACH IN COOLER
Violation Issued: No

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

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. INSPECTION CONDUCTED IN PRESENCE OF THE PERSON IN CHARGE.

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

FOOD SERVICE AREA FLOORS, WALLS, CEILINGS, COUNTERTOPS, AND FINISH MATERIALS MUST BE NON-ABSORBANT, SMOOTH, DURABLE, AND EASILY CLEANABLE. CEILINGS CANNOT HAVE POPCORN TEXTURE. CABINETS CANNOT HAVE HOLLOW BASES. EXPOSED WOOD IS NOT APPROVED FOR FOOD SERVICE AREAS. WOOD IS NOT AN APPROVED FOOD CONTACT SURFACE.

THESE TOPICS WERE DISCUSSED WITH THE PERSON IN CHARGE:
- EMPLOYEE ILLNESS EXCLUSION
- HAND WASHING PROCEDURE
- NO BARE HAND CONTACT WITH RTE FOOD
- VOMIT CLEAN UP PROCEDURE
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS
- ANSI 184 DISH WASHER

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 1023231252 of 12/19/23.

Certified Food Protection Manager: MIRIAM EGBUDOM

Certification Number: 114565 Expires: 12/21/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
MIRIAM EGBUDOM
PERSON IN CHARGE

Signed: Gregory T Nelson
Gregory T. Nelson
Public Health Sanitarian
Freeman Building
651-201-4259
greg.nelson@state.mn.us