Electronically Delivered

November 5, 2024

Licensee
Millennium Health Care LLC
3109 Oakland Avenue
Minneapolis, MN 55407

RE: Project Number(s) SL36473015

Dear Licensee:

On October 7, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the August 1, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

JMD

Electronically Delivered

September 27, 2024

Licensee
Millennium Health Care LLC
3109 Oakland Avenue
Minneapolis, MN 55407

RE: Project Number(s) SL36473015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 1, 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.

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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36473	A. BUILDING: _____ B. WING _____	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLENNIUM HEALTH CARE LLC	3109 OAKLAND AVENUE MINNEAPOLIS, MN 55407

(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: SL36473015-0 On July 29, 2024, through, August 1, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 5 resident(s); 5 receiving services under the provider's Assisted Living Facility 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 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 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 evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated July 29, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter	0 780		

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0 780	Continued From page 2 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 was issued at a widespread scope (when problems are pervasive or represent a systemic	0 780		

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0 780	Continued From page 3 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 31, 2024, from approximately 10:00 a.m. to 11:30 a.m., survey staff toured the facility with licensed assisted living director (LALD)-A and unlicensed personnel (ULP)-D. Survey staff asked ULP-D to initiate a test of the smoke alarms throughout the home. Upon testing, it was found that the smoke alarms in the facility were not interconnected. On July 31, 2024, at 11:30 a.m., LALD-A stated they understood the smoke alarm requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings,	0 800		

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0 800	Continued From page 4 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 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 July 31, 2024, from approximately 10:00 a.m. to 11:30 a.m., survey staff toured the facility with licensed assisted living director (LALD)-A and unlicensed personnel (ULP)-D. The following was observed. GENERAL MAINTENANCE: The light bulbs were burned out in the hallway light fixture outside the elevator door. There was a square cut into the ceiling to allow access to a water shut off valve. A cover must be provided. The upstairs bathroom had water damage on the wall behind the sink and toilet. The towel bar and toilet paper holder were pulled off the wall leaving large holes in multiple locations that exposed the inside of the wall to moisture penetration. The mini-split air conditioning equipment in bedroom 3 was damaged along the bottom of the	0 800		

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0 800	Continued From page 5 unit. A sharp, metal piece of the frame was hanging down directly above the bed. The licensee did not have a key to bedroom 1 and could not access the room in case of an emergency. On July 31, 2024, at 1:30 p.m., LALD-A and ULP-D stated they understood the above-listed deficiencies. 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	0 810		

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0 810	Continued From page 6 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 twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the 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 July 31, 2024, licensed assisted living director (LALD)-A and unlicensed personnel (ULP)-D 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:	0 810		

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0 810	Continued From page 7 The licensee's FSEP, titled "Fire Safety", dated May 25, 2024, failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The provided FSEP was from a third-party provider and had not been updated to the specific facility. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. On July 31, 2024, at 1:30 p.m., LALD-A and ULP-D stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. The policy reviewed was an unedited policy purchased from a third-party provider that was not specific to the facility. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		

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0 820	Continued From page 8	0 820		
0 820 SS=F	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the physical facility elements did not constitute a distinct hazard to life. The licensee had door lock hardware on the egress side of the main level doors leading outside. This had the potential to affect all occupied residents, staff, and visitors because timely evacuation would not be possible in the event of a fire or other life-threatening emergencies. 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).	0 820		

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0 820	Continued From page 9 The findings include: On July 31, 2024, from approximately 10:00 a.m. to 11:30 a.m., survey staff toured the facility with licensed assisted living director (LALD)-A and unlicensed personnel (ULP)-D. The main exit door had a hotel-style chain lock near the top of the door. Required exit doors in this type of facility are allowed to be provided with one security type lock (2 locking devices total) such as the deadbolt, in addition to the door latch lock and installed not more than 48 inches from the floor. ULP-D removed the hotel-style chain lock at the time of the survey. On July 31, 2024, LALD-A and ULP-D stated they understood the exit doors could not have extra locks in addition to a standard latch and deadbolt with a thumb turn. TIME PERIOD FOR CORRECTION: Two (2) days.	0 820		
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	01760		

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01760	Continued From page 10 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 accurately document medications administered for one of three residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On July 30, 2024, at 8:29 a.m., the surveyor observed unlicensed personnel (ULP)-D verify the following medications were due for administration to R1: -gabapentin 300 milligrams (mg) three times daily; -clonidine 0.2 mg twice daily; -losartan potassium 50 mg daily; and -MiraLAX 17 grams (g) daily (mixed with water). ULP-D opened the locked medication closet and grabbed a plastic medication set-up box labeled with R1's name. ULP-D placed pills in a small plastic cup and put the medication set-up box back in the medication closet. ULP-D handed the medications to R1. ULP-D proceeded to mark gabapentin, clonidine, losartan, and MiraLAX as administered, however, ULP-D did not prepare or	01760		

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01760	Continued From page 11 administer R1's MiraLAX. On July 30, 2024, at 9:05 a.m., the surveyor observed the locked medication storage closet contained an unopened and sealed bottle of MiraLAX for R1 dispensed on June 29, 2024. R1 admitted to the licensee on August 20, 2023, and began receiving assisted living services. R1's diagnoses included post-traumatic stress disorder (PTSD), hypertension, bipolar disorder, history of substance abuse, depression, and anxiety. R1's service plan dated August 20, 2023, indicated R1 received assistance with medication administration, activity assistance, housekeeping, laundry, meals, shopping, transportation, behavior management - agitation, behavior management - anxiety, behavior management - physical aggression, behavior management - self-isolation, behavior management - verbal aggression, and behavior management - depression. R1's medication administration record (MAR) dated July 2024, indicated R1's MiraLAX was documented as administered on July 3, 4, 5, 6, 8, 10, 11, 12, 13, 15, 17, 18, 19, 22, 23, 25, 26, 27, and 29, 2024. ULP-D's Medication Administration - Routes competency dated August 14, 2023, indicated ULP-D was deemed competent by clinical nurse supervisor (CNS)-B for the delegated task of medication administration. The competency instructed ULP-D to observe a resident swallow medication, then document administration afterwards.	01760		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLENNIUM HEALTH CARE LLC	3109 OAKLAND AVENUE MINNEAPOLIS, MN 55407

(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
01760	Continued From page 12 On July 30, 2024, at 11:30 a.m., ULP-D stated R1 occasionally took the MiraLAX, but did not take it daily. ULP-D stated the MiraLAX was stored in the locked medication closet. On July 30, 2024, at 11:35 a.m., CNS-B stated she believed staff were making mistakes when documenting R1's MiraLAX as administered as the bottle was unopened. CNS-B stated she would speak with staff. The licensee's Medication Administration policy dated December 24, 2023, indicated prior to delegating the task of medication administration, a RN must instruct a ULP on preparation, administration, and documentation after assistance with medication administration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		

Minnesota Department of Health
Food, Pools, and Lodging Services
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *07/29/24*
Time: 12:00:00
Report: 1013241052

Food and Beverage Establishment Inspection Report

Location:
Millennium Health Care Llc
3109 Oakland Avenue
Minneapolis, MN55407
Hennepin County, 27

Establishment Info:
ID #: 0038355
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6124588070
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.

3-500B Microbial Control: hot and cold holding

3-501.16A2 ***** Priority 1 *****

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

COLD TCS FOOD MEASURED ABOVE 41F IN THE KITCHEN REFRIGERATOR: EGGS 50F, CHEESE 50F, DELI MEAT 51F. PER STAFF THE REFRIGERATOR WAS LEFT OPEN FOR CLEANING. DISCUSSED TEMP CONTROL WITH STAFF AND THE REFRIGERATOR WAS TURNED COLDER.

Comply By: 07/29/24

7-200 Toxic Supplies and Applications

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

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

CHLORINE SANITIZER MEASURED OVER 200 PPM WITH THE FACILITY'S TEST KIT LOCATED IN THE KITCHEN SANITIZER BUCKET. DISCUSSED SANITIZER USE WITH STAFF AND THE SANITIZER SOLUTION WAS REMADE MEASURING 200 PPM CHLORINE.

Corrected on Site

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.

HOT WATER SANITIZING DISH MACHINE IS USED FOR WARE WASHING. THE FACILITY'S HIGH TEMP DISH MACHINE TEST KIT WAS BROKEN. COMPLY WITH ABOVE RULE. DISCUSSED DISH MACHINE TESTING WITH STAFF.

Type: Full
Date: *07/29/24*
Time: 12:00:00
Report: 1013241052
Millennium Health Care Llc

Food and Beverage Establishment Inspection Report

Comply By: 08/09/24

Surface and Equipment Sanitizers

Chlorine: > 200ppm at Degrees Fahrenheit
Location: Sanitizer - kitchen
Violation Issued: Yes

Hot Water: = at 161 Degrees Fahrenheit
Location: Dish machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Deli meat (turkey)
Temperature: 51 Degrees Fahrenheit - Location: Kitchen refrigerator
Violation Issued: Yes

Process/Item: Raw shell eggs
Temperature: 50 Degrees Fahrenheit - Location: Kitchen refrigerator
Violation Issued: Yes

Process/Item: Cheese
Temperature: 50 Degrees Fahrenheit - Location: Kitchen refrigerator
Violation Issued: Yes

Process/Item: Milk
Temperature: 40 Degrees Fahrenheit - Location: Basement refrigerator
Violation Issued: No

Process/Item: Meat
Temperature: 27 Degrees Fahrenheit - Location: Freezer
Violation Issued: No

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

The inspection was completed with the operator then reviewed with MDH Nurse Evaluator J. Schoenecker.

The establishment has a residential kitchen and serves food that is prepared that day. The kitchen has wood cabinets, vinyl floor, painted walls, solid counter top, and a smooth painted ceiling.

A two basin sink is located in the kitchen. One basin is designated for hand washing.

A residential dish machine is used to wash ware. The dish machine is run on the sanitize/high temperature cycle.

Discussed hand washing, ware washing, staff illness policy, temperature control, final cook temperatures, cleaning, serving highly susceptible populations, glove use, and food handling procedures.

Type: Full
Date: *07/29/24*
Time: 12:00:00
Report: 1013241052
Millennium Health Care Llc

Food and Beverage Establishment Inspection Report

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 1013241052 of 07/29/24.

Certified Food Protection Manager: Nasra Ali

Certification Number: 114518 Expires: 12/04/28

Inspection report reviewed with person in charge and emailed.

Signed: _____
Nasra Ali
Operator

Signed: JM
Jerry Malloy
Sanitarian Supervisor
FPLS Metro
651-201-3998
jerry.malloy@state.mn.us