Electronically Delivered

March 31, 2023

Licensee
Amira Choice Roseville At Lexington
2680 Lexington Avenue North
Roseville, MN 55113

RE: Project Number(s) SL33262015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on February 24, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health 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.

LICENSING ORDERS
The enclosed State Form documents the state licensing orders. The Department of Health 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 and enforcement actions based on the level and scope of the violations; **however, no immediate fines are assessed for this evaluation of your facility**.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction 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 issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-3789 Fax: 651-281-9796
JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33262	A. BUILDING: _____ B. WING _____	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMIRA CHOICE ROSEVILLE AT LEXINGTON	2680 LEXINGTON AVENUE NORTH ROSEVILLE, MN 55113

(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: SL33262015-0 On February 21, through February 27, 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 133 active residents; 72 receiving services under the Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing 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 included document titled, Food and Beverage Establishment Inspection Report dated February 21, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 630 SS=D	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	0 630		

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0 630	Continued From page 2 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 observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan was updated to include person's risk of abusing other vulnerable adults and statements of the specific measures to be taken to minimize the risk of abuse for one of one resident (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On February 22, 2023, at 1:00 p.m., surveyor observed R5 walking around the room looking for her compression socks. Surveyor was followed R5 and found two pairs of metal scissors in R5's bathroom medicine cabinet which was right at entry of the bathroom. One scissor had a blunt tip, and the other pair of scissors had a sharp tip. R5 and surveyor began to walk out of the apartment and came across another resident clearly upset with a staff person. R5 yelled to that	0 630		

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0 630	Continued From page 3	0 630		

resident "stop being so dramatic," and the other resident began to get closer to R5. Surveyor and R5 continued walking toward the dining room away from the other resident.

R5's diagnoses included vascular dementia with behavioral disturbance, venous insufficiency (backflow of blood), hyperlipidemia (high cholesterol), recurrent falls, and lymphedema (swelling).

R5's provider visit note on November 4, 2022, indicated under the title Physical Exam that it is "not uncommon that R5 will stand in her doorway and look at people coming down the hallway and make comments. She did have an altercation with another resident this past week. No injuries."

R5's provider visit note on November 18, 2023, indicated under the title Assessment/Plan that R5 will "occasionally have an altercation with her peers. No changes with her medications which are geared to help with anxiety and paranoid thoughts.

R5's Comprehensive Assessment/Licensed Services dated December 4, 2022, indicated R5 had agitation/increased anxiety. Under vulnerabilities and abuse prevention, it was assessed by an RN that R5 did not pose a risk to abusing others verbally, physically or with threatening behavior.

R5's Service Plan Agreement signed on December 20, 2022, indicated R5 was receiving services to include diversional activities, laundry, medication and treatment administration, toileting, dressing, and grooming assistance.

R5's Medication Sheet dated February 2023,

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0 630	Continued From page 4 indicated R5 was taking trazodone 50 milligram (mg) tablet - 1/2 tab (25mg) by mouth three times a day at 8:00 a.m., 12:00 p.m. and 5:00 p.m., then trazodone 100 mg by mouth at bedtime for behavior. R5 also took quetiapine 25 mg tablet by mouth daily at 5:00 p.m. for behavior. On February 23, 2023, at approximately 1:10 p.m., surveyor notified director of nursing (DON)-A that sharp scissors were found in the medicine cabinet in R5's bathroom. DON-A stated "that should not have been in there. We do not use those kinds of scissors. I will let the homecare agency know." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
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.	0 660		

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0 660	Continued From page 5 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 and screening for one of two employees (licensed practical nurse (LPN)-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) 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: The licensee's TB facility risk assessment tool dated February 21, 2023, indicated the licensee had a low risk for TB. LPN-C was hired on April 5, 2021. LPN-C's record included a TB QuantiFERON Gold Plus NIL-Past results (TB blood test) document dated August 22, 2020. This blood test was completed 226 days before hire. LPN-C's record lacked a TB baseline screening at hire. On February 22, 2023, at 12:17 p.m., surveyor requested LPN-C's baseline screening upon hire and director of nursing (DON)-A provided the TB Signs and Symptoms form dated March 4, 2021.	0 660		

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0 660	Continued From page 6 On February 23, 2023, at 1:00 p.m., during the exit conference, DON-A provided the TB procedure plan but not the TB Baseline screening for LPN-C as requested. The licensee's TB Screening and Prevention policy last reviewed on November 30, 2020, indicated the licensee would screen staff upon hire for TB and maintain all reports of TB screening in the personnel files of employees. The policy also indicated staff may begin working with residents after a negative TB symptom screen and a documented negative interferon gamma release assay (IGRA) or first step of a two-step skin test (TST) dated within 90 days before hire. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
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 of the facility in a continuous state of good repair and	0 800		

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0 800	Continued From page 7 operation. This has the potential to directly affect the health, safety, and well-being of all residents and staff. 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 February 24, 2023, approximately from 10:40 a.m. to 2:30 p.m., survey staff toured the facility with the environmental services director (ESD)-E and the licensed assisted living director (LALD)-D. During the tour, survey staff observed the following: 1. The exterior walkway in the courtyard of a marked exit door in the memory care dining room had a snow cover that had not been maintained in the means of egress from a building exit door to a publicway. 2. The air filters for the "PTAC" wall-mounted units and the "Magic Pak" heating and cooling units through-out the resident apartment units were dusty and needed to be cleaned. The ESD-E verified the findings and stated that a work order has been issued to perform deep cleaning of all filters this month. The ESD-E explained that their routine schedule for filters is annual but they will review and revise the schedule for a more frequent filter cleaning schedule. 3. Extension cords were used in units 19 and 20 that posed a potential electrical fire hazard from overloading the electrical circuits.	0 800		

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0 800	Continued From page 8 4. FIRE RATED DOORS -The trash rooms and the storage room located on the parking-level floor had fire-rated doors that failed to positively latch to maintain the fire rating of the rooms. In addition, one of the fire-rated trash room doors also had damaged door hardware. -The trash room fire-rated door located next to unit 318 on the 3rd floor was missing a door self-closing hardware preventing the door from self-closing to maintain the fire rating of the trash room. -Inside the 4th-floor trash room near unit 418, the trash chute protective cover failed to automatically close after use. Survey staff observed the 18-inch by 18-inch chute protective cover in the fully open position. -The 2nd-floor 90-minute fire-rated stairway door (C) failed to latch when closed for proper fire protection of vertical opening. The above findings were visually verified by the ESD-E and/or the LALD-D accompanying the tour. On February 24, 2023, at approximately 3:15 p.m., during the exit interview, the LALD-D and the ESD-E acknowledged the above findings. The ESD-E stated all work has been issued work orders for corrections. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the	01060		

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01060	Continued From page 9 facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes	01060		

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01060	Continued From page 10 a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation for three of three residents (R2, R3, R4). 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: R2 R2 started receiving services on July 14, 2020, under the comprehensive license and started receiving assisted living services August 1, 2021. R2's Service Plan Agreement dated October 5, 2022, indicated R2 received assistance with medication administration, oxygen use, and C-PAP (continuous positive airway pressure) use. R2's record indicated R2 went to the emergency room on September 5, 2022, and was admitted to the hospital. R2 returned to the facility on September 30, 2022. R3 R3 started receiving assisted living services on	01060		

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01060	Continued From page 11 April 20, 2022. R3's Service Plan Agreement dated September 1, 2022, indicated R3 received assistance with medication administration, transfers, and ambulation. R3's record indicated R3 went to the emergency room February 2, 2023, and was admitted to the hospital. R3 returned to the facility on February 10, 2023. R4 R4 started receiving assisted living services on June 16, 2022. R4's Service Plan Agreement dated October 07, 2022, indicated R4 received assistance with medication administration, transfers, blood glucose monitoring, and toileting. R4's record indicated R4 went to the emergency room January 24, 2023, and was admitted to the hospital. R4's record indicated R4 discharged from the hospital and transferred to a transitional care unit (TCU) January 26, 2023. R4's record indicated TCU anticipated R4 to remain at TCU for another two weeks. R2, R3, and R4's records lacked a written notice including: - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and	01060		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMIRA CHOICE ROSEVILLE AT LEXINGTON	2680 LEXINGTON AVENUE NORTH ROSEVILLE, MN 55113

(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
01060	Continued From page 12 - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. R2, R3, and R4's records lacked notification to the Office of Ombudsman for Long-Term Care that the resident had been relocated and had not returned to the facility within four days. On January 22, 2023, at 1:15 p.m., director or nursing (DON)-A stated the corporate office sent their facility the emergency relocation form to start using on February 6, 2023. DON-A stated the emergency relocation form had not been used with any residents and were unaware the ombudsman needed to be notified of a resident being out of the facility for more than four days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		

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

Type: Full
Date: *02/21/23*
Time: 10:19:32
Report: 1023231071

Food and Beverage Establishment Inspection Report

Location:
Amira Chose Roseville at Lexin
2680 Lexington Avenue North
Roseville, MN55113
Ramsey County, 62

Establishment Info:
ID #: 0037644
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6517662266
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 previously issued on 02/21/23 have NOT been corrected.

5-200B Plumbing: cross connections

5-203.14I ** Priority 1 **

MN Rule 4626.1085A Remove the control valve located on the discharge side of the atmospheric vacuum breaker backflow prevention device.

OBSERVED WYE SPLITTER WITH CONTROL VALVES INSTALLED ON MOP FAUCET WITH AVB. REPLACE WYE VALVE WITH APPROVED PRESSURE BLEEDING DEVICE. EXAMPLES OF APPROVED DEVICES SENT TO OPERATOR.

Issued on: 02/21/23 *Comply By: 02/21/23*

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.

HIGH TEMPERATURE DISH MACHINE IN USE BUT OPERATOR STATED NO IRREVERSIBLE TEMPERATURE DEVICE PRESENT. ACQUIRE AND USE THIS DEVICE TO ENSURE EFFECTIVE PATHOGEN ELIMINATION.

Issued on: 02/21/23 *Comply By: 02/21/23*

4-500 Equipment Maintenance and Operation

4-501.12

MN Rule 4626.0740 Resurface scratched or scored cutting blocks and boards or discard if they can no longer be effectively cleaned and sanitized or resurfaced.

OBSERVED CUTTING SCORED BOARDS BEING USED AS FOOD CONTACT SURFACE. REPAIR/REPLACE CUTTING BOARDS SO THEY CAN BE EASILY CLEANED.

Issued on: 02/21/23 *Comply By: 02/21/23*

4-600 Cleaning Equipment and Utensils

4-602.12

MN Rule 4626.0850 Clean the food contact surfaces of cooking and baking equipment and interior cavities of microwave ovens at least every 24 hours.

OBSERVED ACCUMULATION OF DRIED FOOD DEBRIS ON TOP PORTION OF MICROWAVE INTERIOR.

Issued on: 02/21/23 *Comply By: 02/21/23*

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

NO HAND WASH SIGN AT HAND SINK NEAR PREP COOLER. SAMPLE SIGN SENT TO OPERATOR.

Issued on: 02/21/23 *Comply By: 02/21/23*

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.

MEASURED TCS FOODS AT UNSAFE TEMPERATURE (FISH IN DRAWER COOLER). ALWAYS KEEP THESE FOODS AT 41dF OR COLDER TO PREVENT PATHOGEN GROWTH.

Comply By: 02/21/23

4-500 Equipment Maintenance and Operation

4-501.11AB

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

MEASURED TCS FOODS AT UNSAFE TEMPERATURE (FISH IN DRAWER COOLER). REPAIR/REPLACE EQUIPMENT TO ALWAYS KEEP FOODS AT 41dF OR LESS.

Comply By: 02/21/23

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200PPM at Degrees Fahrenheit
Location: SANI BUCKET
Violation Issued: No

Quaternary Ammonia: = at 161 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/BURGER
Temperature: 43 Degrees Fahrenheit - Location: DRAWER COOLER
Violation Issued: Yes

Food and Beverage Establishment Inspection Report

Process/Item: Cold Hold/FISH
Temperature: 43 Degrees Fahrenheit - Location: DRAWER COOLER
Violation Issued: Yes

Process/Item: Cold Hold/CUT TOMATO
Temperature: 40 Degrees Fahrenheit - Location: PREP COOLER
Violation Issued: No

Process/Item: Cold Hold/CHHESE
Temperature: 41 Degrees Fahrenheit - Location: WALK IN COOLER
Violation Issued: No

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

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

ALL VIOLATIONS WERE DISCUSSED WITH PERSON IN CHARGE AND HRD EVALUATOR DURING INSPECTION. FOR CORRECT BY DATES REFER TO COMPLETE REPORT ISSUED BY HRD.

THIS FACILITY CONSISTS OF A FULL SERVICE MAIN KITCHEN AREA WITH TYPE I HOOD/ANSUL AND PREP SINK. FOOD SERVICE IS PROVIDED BY FACILITY STAFF.

THESE TOPICS WERE DISCUSSED WITH THE PERSON IN CHARGE:
- EMPLOYEE ILLNESS EXCLUSION
- HAND WASHING PROCEDURE
- NO BARE HAND CONTACT WITH RTE FOOD
- FOOD COOLING METHODS
- VOMIT CLEAN UP PROCEDURE
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS
- PASTEURIZED SHELL EGGS

THIS REPORT IS IDENTICAL TO REPORT #1023231038 WHICH WAS ENTERED WITH THE PREVIOUS OPERATOR'S LICENSE NAME.

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 1023231071 of 02/21/23.

Certified Food Protection Manager: JACLYN VON

Certification Number: 107227 Expires: 04/20/24

Inspection report reviewed with person in charge and emailed.

Signed: _____

JACLYN VON
PERSON IN CHARGE

Signed: Gregory T Nelson

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

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

Type: Follow-Up
Date: *02/23/23*
Time: 10:24:56
Report: 1023231072

Food and Beverage Establishment Inspection Report

Location:
Amira Chose Roseville at Lexin
2680 Lexington Avenue North
Roseville, MN55113
Ramsey County, 62

Establishment Info:
ID #: 0037644
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6517662266
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 previously issued on 02/21/23 have NOT been corrected.

5-200B Plumbing: cross connections

5-203.14I ** Priority 1 **

MN Rule 4626.1085A Remove the control valve located on the discharge side of the atmospheric vacuum breaker backflow prevention device.

OBSERVED WYE SPLITTER WITH CONTROL VALVES INSTALLED ON MOP FAUCET WITH AVB. REPLACE WYE VALVE WITH APPROVED PRESSURE BLEEDING DEVICE. EXAMPLES OF APPROVED DEVICES SENT TO OPERATOR.

Issued on: 02/21/23 *Comply By: 02/21/23*

4-300 Equipment Numbers and Capacities

4-302.13B ** Priority 2 **

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HIGH TEMPERATURE DISH MACHINE IN USE BUT OPERATOR STATED NO IRREVERSIBLE TEMPERATURE DEVICE PRESENT. ACQUIRE AND USE THIS DEVICE TO ENSURE EFFECTIVE PATHOGEN ELIMINATION.

Issued on: 02/21/23 *Comply By: 02/21/23*

4-500 Equipment Maintenance and Operation

4-501.12

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Issued on: 02/21/23 *Comply By: 02/21/23*

Food and Beverage Establishment Inspection Report

4-600 Cleaning Equipment and Utensils

4-602.12

MN Rule 4626.0850 Clean the food contact surfaces of cooking and baking equipment and interior cavities of microwave ovens at least every 24 hours.

OBSERVED ACCUMULATION OF DRIED FOOD DEBRIS ON TOP PORTION OF MICROWAVE INTERIOR.

Issued on: 02/21/23 *Comply By: 02/21/23*

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

NO HAND WASH SIGN AT HAND SINK NEAR PREP COOLER. SAMPLE SIGN SENT TO OPERATOR.

Issued on: 02/21/23 *Comply By: 02/21/23*

No NEW orders were issued during this inspection.

Food and Equipment Temperatures

Process/Item: Cold Hold/BURGER
Temperature: 37 Degrees Fahrenheit - Location: DRAWER COOLER
Violation Issued: No

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

INSPECTOR VERIFIED SAFE FOOD TEMPERATURES IN DRAWER COOLER.

THIS REPORT IS IDENTICAL TO REPORT #1023231038 WHICH WAS ENTERED UNDER THE PREVIOUS OPERATOR'S INFORMATION.

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 1023231072 of 02/23/23.

Certified Food Protection Manager: JACLYN VON

Certification Number: 107227 Expires: 04/20/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
JACLYN VON
PERSON IN CHARGE

Signed: Gregory T Nelson
Gregory T. Nelson
Public Health Sanitarian
Freeman Building
651-201-4259

Gregory T Nelson

greg.nelson@state.mn.us