Electronically Delivered

August 30, 2023

Licensee
Willows Of Ramsey Hill
80 North Mackubin Street
Saint Paul, MN 55102

RE: Project Number(s) SL31573015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 10, 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 and enforcement actions 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.

A state correction 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).

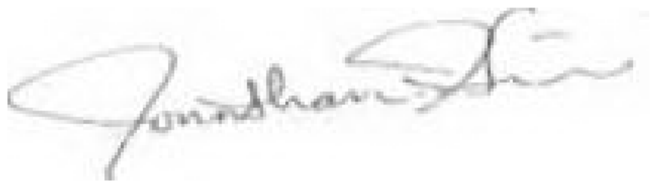
Please address your cover letter for reconsideration requests to:

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 the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,



Jonathan Hill, Supervisor
State Evaluation Team
Email: jonathan.hill@state.mn.us
Telephone: 651-201-3993 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
	31573	A. BUILDING: _____ B. WING _____	08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS OF RAMSEY HILL	80 NORTH MACKUBIN STREET SAINT PAUL, MN 55102

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL31573015-0 On August 7, 2023, through August 10, 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 56 active residents, all of whom receiving services under the Assisted Living with Dementia Care 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 with Dementia Care 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 (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 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 had the potential to affect all residents of the assisted living facility. 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 August 7, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted	01620		

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01620	Continued From page 2 as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted a comprehensive nursing assessment after initiating hospice services, for two of four residents (R4, 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, 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:	01620		

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01620	Continued From page 3 R4 R4's unsigned service plan dated August 8, 2023, indicated R4 received services including assistance with morning and evening cares, cues for eating, bathing, bed mobility, weekly vital signs, oxygen maintenance, weekly laundry, medication set up, medication administration, toileting, and safety checks. R4's progress note dated April 11, 2023, at 4:17 p.m., indicated R4 had been admitted to hospice services with a primary diagnosis of congestive heart failure. R4's record lacked a comprehensive RN assessment after being admitted to hospice services. R5 R5's service plan, signed May 18, 2023, indicated R5 received services including assistance with eating cues, am and pm cares, showers, transfers, catheter cares, mechanical soft diet, dressing change on coccyx, medication set up, medication administration, toileting, and safety checks. R5's progress note dated May 25, 2023, at 4:00 p.m., indicated R5 was admitted to hospice services with a primary diagnosis of Alzheimer's disease. R5's record lacked a comprehensive RN assessment after being admitted to hospice services. On August 8, 2023, at 1:45 p.m., clinical nurse supervisor, (CNS)-B stated she did not complete an in-person assessment on R4 or R5 after	01620		

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01620	Continued From page 4 admission to hospice services to observe if there was any change in condition or added services. CNS-B did not think going on hospice services warranted an assessment but after discussing with her regional team completing an assessment was what was expected from the licensee after the addition of hospice services. CNS-B further stated if more audits were completed on hospice admission records, surveyors would find none of them had an assessment completed. CNS-B stated the licensee would start doing full assessments after each hospice admission to determine needs and changes. The licensee's Assessments, Reviews and Monitoring policy, effective August 1, 2022, indicated, "resident reassessment and monitoring must be conducted no more than 14 calendar days after the initiation of services. Ongoing resident re-assessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the first date of the assessment." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting	01640		

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01640	Continued From page 5 agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan was updated and included a signature or other authentication by the resident and the facility to document agreement on the services to be provided for three of four residents (R2, R4, 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 a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2	01640		

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01640	Continued From page 6 R2's service plan, signed November 3, 2022, indicated R2 received services including assistance with medication management, blood glucose monitoring, shower, activities of daily living (ADLs), laundry, toileting, assistance with CPAP (continuous positive airway pressure - breathing aid worn while sleeping), and stand-by assistance with walker. R2's hospice plan of care dated April 4, 2023, indicated hospice services to start April 4, 2023, including, but not limited to: durable medical equipment (DME) including Broda chair, hospital bed, sit-to-stand lift, and services of registered nurse (RN), medical social worker, spiritual care, and certified nursing assistant (CNA). On August 8, 2023, at 9:00 a.m., surveyor observed unlicensed personnel (ULP)-C complete R2's medication pass, blood sugar check and morning cares. ULP-C and ULP-D used sit-to-stand lift to get R2 out of hospital bed and on to toilet, washed R2 up, ULP-C changed R2's clothes, and incontinent brief. ULP-C and ULP-D used the sit to stand lift to get R4 in the Broda chair for breakfast. R2's service plan lacked identification of increased level of services provided, as identified in the hospice plan of care, including a signature or other authentication by the resident and the facility. R4 R4's service plan, signed March 24, 2023, indicated R4 received services including assistance with medication management, ADLs, eating cues, whirlpool bath, transfers with assist of 1-2, repositioning, laundry, toileting, and safety checks.	01640		

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01640	Continued From page 7 R4's progress note dated April 13, 2023, indicated R4 was admitted to hospice services April 11, 2023, with a primary diagnosis of congestive heart failure. R4's hospice plan of care, dated April 11, 2023, indicated hospice services to start April 11, 2023, including DME including hospital bed and hospice services of a CNA, RN, spiritual care, and social worker. R4's record included an unsigned service plan, printed August 8, 2023. The service plan indicated R4 received the following added services: monitoring vital signs, and oxygen management. R4's record lacked an updated service plan including a signature or other authentication by the resident and the facility to document agreement on the services to be provided as identified in the hospice plan of care and unsigned service plan. R5 R5's service plan signed May 18, 2023, indicated R5 received services including assistance with medication management, eating cues, ADLs, shower, catheter care, wound care, safety checks, toileting, and transfer with assist of one. R5's progress note dated May 30, 2023, indicated R5 admitted for hospice services on May 25, 2023, with a primary diagnosis of Alzheimer's disease. R5's hospice plan of care, dated May 25, 2023, indicated hospice services to start May 25, 2023, including	01640		

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01640	Continued From page 8 DME including air mattress, hospital bed; social services and spiritual care. R5's record lacked an updated service plan including a signature or other authentication by the resident and the facility to document agreement on the services to be provided as identified in the hospice plan of care. On August 8, 2023, at 1:45 p.m., clinical nursing supervisor (CNS)-B stated they had not completed service plan updates for hospice admissions and they were not aware they should. CNS-B further stated they would update service plans accordingly, going forward. CNS-B further stated they had not completed change in condition assessments after hospice admissions and if surveyor audited additional records, the surveyor would find they were not completed for any hospice admissions. The licensee's service plan policy, dated August 1, 2021, indicated, "The service plan and any revisions shall include a signature or other authentication by [licensee] and by the resident or resident's representative, documenting agreement on the services to be provided. Service plans shall be revised, if needed, based on resident reassessments and monitoring." No further information was provided. TIME PERIOD TO CORRECT- Twenty-one (21) days.	01640		
02180 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (e) Behavioral symptoms that negatively impact	02180		

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02180	Continued From page 9 the resident and others in the assisted living facility with dementia care must be evaluated and included on the service or care plan. The staff must initiate and coordinate outside consultation or acute care when indicated. (f) Support must be offered to family and other significant relationships on a regularly scheduled basis but not less than quarterly. (g) Existing housing with services establishments registered under chapter 144D prior to August 1, 2021, that obtain an assisted living facility license must provide residents with regular access to outdoor space. A licensee with new construction on or after August 1, 2021, or a new licensee that was not previously registered under chapter 144D prior to August 1, 2021, must provide regular access to secured outdoor space on the premises of the facility. A resident's access to outdoor space must be in accordance with the resident's documented care plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure behavioral symptoms were addressed on the service plan for two of two residents (R2, 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 of the residents). The findings include: The licensee had an Assisted Living with	02180		

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02180	Continued From page 10 Dementia Care (ALFDC) license effective June 1, 2022. R2 R2's diagnoses included dementia, agitation with refusal of cares, and history of falls. R2's unsigned service plan dated August 7, 2023, indicated R2 received services including medication set up, medication administration, weekly vital signs, weekly shower, assistance to the bathroom, approach client from the left as he is blind in right eye, crush medications, weekly laundry, pre-medicate for cares to decrease agitation, A.M., and P.M. cares, blood sugar checks with the libre machine, stand by assistance with gait belt for toileting, stand by assist with walker usage, and CPAP machine. R2's hospice plan of care dated April 4, 2023, indicated daily behaviors and a mood stabilizer ordered. Plan of care indicated in summary of problems, resident could have periods of increased anxiety and be resistive to care. On August 8, 2023, at 9:00 a.m., surveyor observed unlicensed personnel (ULP)-C complete R2's medication pass, blood sugar check and morning cares. ULP-C and ULP-D used sit to stand lift to get R2 out of hospital bed and on to toilet, washed R2 up, R2 became agitated and refused to brush his teeth or let care givers shave him, ULP-C changed R2's clothes, and incontinent brief. ULP-C and ULP-D used the sit to stand lift to get R4 in the Broda chair for breakfast. R2 remained agitated after cares and stated he did not want to eat. On August 8, 2023, at 9:25 a.m. ULP-D stated R2 could become very agitated with cares, staff used	02180		

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02180	Continued From page 11 2 ULPS to complete cares for safety. ULP-D stated staff pre-medicated resident for agitation which helped resident be more accepting of cares. ULP-D stated staff should report behaviors and refusals to the nurse for charting, but staff did not get a chance to do that due to time. ULP-D stated they currently did not have anything in the electronic health record (EHR) to record behaviors. R4 R4's diagnoses included dementia with behaviors, end stage heart failure, major depressive disorder, and history of falls. R4's unsigned service plan dated August 8, 2023, indicated R4 received services including assistance with morning and evening cares, cues for eating, bathing, bed mobility, vital signs, oxygen maintenance, weekly laundry, medication set up, daily medication administration, toileting, and safety checks. R4's progress note dated April 11, 2023, at 4:17 p.m., indicated R4 had been admitted to hospice services with a primary diagnosis of congestive heart failure. R4's hospice plan of care dated April 11, 2023, indicated R4 had a history of verbally abusing female caregivers of color, periods of anxious behavior and self-isolation including refusing to leave her room. On August 8, 2023, at 7:30 a.m., ULP-C stated R4 could become very agitated with cares and resistive. R4 had a history of self-isolating in her room, both licensee and hospice offered her more socialization. Staff and Hospice provided encouragement and assistance to get out of	02180		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS OF RAMSEY HILL	80 NORTH MACKUBIN STREET SAINT PAUL, MN 55102

(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
02180	Continued From page 12 resident room. ULP-C stated there was not a place to list difficult behaviors, self-isolation, or refusal of cares when R4 would get anxious, in the electronic health record. ULP-C stated she reported this to nursing when she remembered. ULP-C admitted to forgetting to do this regularly but would chart daily if it was an option in the chart. On August 8, 2023, at 3:30 p.m., clinical nursing supervisor (CNS)-B stated licensee did not include behaviors or interventions for behaviors in the service plan. Licensee did not assess for behaviors previously in the full assessment and therefore the only documentation for behaviors was if an as needed medication is given. CNS-B stated after discussion with her regional nurse vice president they would add questions to the full nursing assessment about behaviors and if the answer was yes, licensee would include a behavior tracking section to the EHR, along with adding behaviors to the service plan. CNS-B stated she reviewed charts of R2 and R4 and agreed there was no bahavior tracking system for these residents that should have been continually monitored. CNS-B stated she was not aware of the need to track behaviors wholistically and surveyors would not find any behaviors listed on service plans at this time. The licensee's Behavioral Symptoms, Interventions & Nonpharmacological Approaches policy dated August 1, 2021, indicated the licensee would identify behavioral symptoms that negatively impact other residents and evaluate to determine potential interventions to minimize such behaviors. Interventions would be identified on the care plan or service plan. No further information was provided.	02180		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31573	A. BUILDING: _____ B. WING _____	08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS OF RAMSEY HILL	80 NORTH MACKUBIN STREET SAINT PAUL, MN 55102

(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
02180	Continued From page 13 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02180		

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

Type: Full
Date: *08/07/23*
Time: 14:45:48
Report: 1021231235

Food and Beverage Establishment Inspection Report

Location:
Willows Of Ramsey Hill
80 North Mackubin Street
St Paul, MN55102
Ramsey County, 62

Establishment Info:
ID #: 0038820
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 6513135481
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.

4-300 Equipment Numbers and Capacities

4-302.14 ***** Priority 2 *****

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

THE TEST KIT ON-SITE FOR THE QUATERNARY AMMONIUM WAS ALREADY EXPIRED. PER CONVERSATION WITH STAFF, THEY ALREADY ORDERED A NEW TEST KIT.

Comply By: 08/11/23

4-300 Equipment Numbers and Capacities

4-302.14 ***** Priority 2 *****

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

ESTABLISHMENT COULD NOT FIND THE MEASURING DEVICE THAT INDICATES THE FINAL UTENSIL SURFACE TEMPERATURE IN DISH MACHINE. PROVIDE.

Comply By: 08/14/23

4-600 Cleaning Equipment and Utensils

4-601.11A ***** Priority 2 *****

MN Rule 4626.0840A Equipment food-contact surfaces and utensils must be clean to sight and touch.

MEAT SLICER BLADE CONTAINS ACCUMULATION OF DRIED FOOD DEBRIS. DISASSEMBLE MEAT SLICER AFTER EACH USE TO BE ABLE TO FULLY CLEAN AND SANITIZE IT. STAFF WILL CLEAN AND SANITIZE THE MEAT SLICER BEFORE USING IT.

Comply By: 08/09/23

6-300 Physical Facility Numbers and Capacities

6-303.11A

MN Rule 4626.1470A Provide at least 10 foot candles (108 LUX) of light intensity at a distance of 30 inches from the floor in the walk-in refrigeration units, dry food storage areas, and in other areas during periods of cleaning.

THE LIGHT BULBS INSIDE THE WALK-IN COOLER ARE DIM. PER CONVERSATION WITH STAFF, THEY ALREADY ORDERED NEW LIGHT BULBS. REPLACE THE LIGHT BULBS SO THEY PROVIDE THE LIGHT INTENSITY LISTED ABOVE.

Comply By: 08/14/23

Surface and Equipment Sanitizers

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

Quaternary Ammonia: = 400PPM at Degrees Fahrenheit
Location: THREE COMPARTMENT SINK
Violation Issued: No

Final Utensil Surface Temp: = at 173 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 34 Degrees Fahrenheit - Location: GRAVY - NORLAKE UPRIGHT COOLER
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: RED SAUCE - NORLAKE UPRIGHT COOLER
Violation Issued: No

Process/Item: Hot Holding
Temperature: 180 Degrees Fahrenheit - Location: AU JUS - HOT WELLS
Violation Issued: No

Process/Item: Hot Holding
Temperature: 177 Degrees Fahrenheit - Location: GRAVY - HOT WELLS
Violation Issued: No

Process/Item: Hot Holding
Temperature: 179 Degrees Fahrenheit - Location: POT ROAST - HOT WELLS
Violation Issued: No

Process/Item: Hot Holding
Temperature: 204 Degrees Fahrenheit - Location: PEAS - HOT WELLS
Violation Issued: No

Type: Full
Date: *08/07/23*
Time: 14:45:48
Report: 1021231235
Willows Of Ramsey Hill

Food and Beverage Establishment Inspection Report

Process/Item: Hot Holding
Temperature: 192 Degrees Fahrenheit - Location: MASHED POTATOES - HOT WELLS
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: POTATO SALAD - WALK-IN COOLER
Violation Issued: No

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

Process/Item: Hot Holding
Temperature: 198 Degrees Fahrenheit - Location: BEEF AND VEGETABLE - WALK-IN COOLER
Violation Issued: No

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

ALL FINDINGS ON THIS REPORT WERE DISCUSSED WITH VICE PRESIDENT OF CULINARY SERVICES, JON TORMOEN, CHEF, BETH MCHENRY AND HEALTH REGULATION DIVISION NURSE EVALUATOR, ROCHELLE FOX.

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 1021231235 of 08/07/23.

Certified Food Protection Manager: BETH A. MCHENRY

Certification Number: FM104352 Expires: 10/12/23

Inspection report reviewed with person in charge and emailed.

Signed: _____

JON TORMOEN
VP OF CULINARY SERVICES

Signed: _____

Melissa Ramos
Environmental Health Specialist
Metro District Office
651-201-4495
Melissa.Ramos@state.mn.us