Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

November 18, 2024

Licensee
Customize Living LLC
3237 2nd Avenue South
Minneapolis, MN 55408

RE: Project Number(s) SL39269015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial survey on October 10, 2024, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

The Department of Health concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. The Department of Health documents state correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care 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 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 . . ."

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00

The total amount you are assessed is $500.00. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per 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 residents/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 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.

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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by MDH within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. To submit a hearing request, please visit **https://forms.web.health.state.mn.us/form/HRDAppealsForm**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration or a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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,

Renee L. Anderson

Renee L. Anderson, Supervisor
State Rapid Response Team
Email: Renee.L.Anderson@state.mn.us
Telephone: 651-201-5871 Fax: 1-800-337-9238

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39269	A. BUILDING: _____ B. WING _____	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUSTOMIZE LIVING LLC	3237 2ND AVENUE SOUTH MINNEAPOLIS, MN 55408

(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: SL39269015-0 On October 7, 2024, through October 10, 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 two residents; both receiving services under the provider's provisonal assisted living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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 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 (FBEIR) dated October 8, 2024, for the specific Minnesota Food Code deficiencies. 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		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that	0 510		

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0 510	Continued From page 2 complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to establish and maintain an effective infection control program that complied with accepted health care, medical and nursing standards for infection control. 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 October 9, 2024, at 12:00 p.m., owner (O)-A provided the licensee's infection control program (ICP) in a three-ring binder. The licensee's ICP did not address current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in assisted living facilities including policies and procedures for the following:	0 510		

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0 510	Continued From page 3 - Person(s) assigned to oversee the ICP are qualified individuals with training in infection prevention and control to manage the licensee's infection prevention program; - Education and training on infection prevention was job specific; - Training was required before individuals were allowed to perform their duties; - How to provide appropriate infection prevention to residents, family members, visitors, and others; - Infection prevention practices and infection control requirements were identified and monitored; - Prompt feedback provided on adherence and related outcomes to healthcare personnel and facility leadership; and - Surveillance plan to monitor the incidences of infections that may be related to care at the facility; and - Standard precaution procedures including: --Hand hygiene --Environmental cleaning and disinfection --Injection and medication safety --Risk assessment with use of appropriate personal protective equipment - Disinfection of reusable medical equipment between each resident or when soiled. - When transmission-based precautions should be implemented, as well as what PPE was needed for each precaution type. On October 9, 2024, at 12:25 p.m., O-A stated the licensee utilized the same ICP from a sister facility, health facility identification number (HFID) 35628, and did not establish and maintain an ICP that complied with accepted health care, medical and nursing standards for infection control for all of the residents and staff of this specific facility. No further information was provided.	0 510		

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0 510	Continued From page 4 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 510		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all	0 680		

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0 680	Continued From page 5 residents, employees, and visitors to the 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 of the residents). The findings include: On October 8, 2024, at 10:45 a.m., owner (O)-A provided the emergency preparedness binder and stated it "was everything." The licensee's EP plan lacked the following required content: -current, all-hazards approach facility assessment -description of the population served by licensee -process for emergency preparedness (EP) cooperation with state and local EP officials/organizations -subsistence needs for staff and residents during an emergency -procedure for tracking staff and residents -development of all policies/procedures, based on assessment -development of a communication plan, including primary and alternate means for communication -methods for sharing information -EP training and testing program -EP training program for staff (including documentation of training provided) -annual EP testing requirements. - process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response. - process for arrangements with other	0 680		

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0 680	Continued From page 6 facilities/providers to receive residents in the event of limitation/cessation of operations to maintain the continuity of services to residents. - policies and procedures on volunteers; and - process to address the role of the facility under a waiver declared by the secretary in accordance with section 1135 of the act. On October 8, 2024, at 1:15 p.m., O-A stated they did not develop a disaster program to apply specifically to this facility. In addition, education/training, and drills were not completed. The licensee's Emergency Preparedness policy, dated October 30, 2023, indicated the licensee, "will have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
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 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;	0 780		

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0 780	Continued From page 7 (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 comply with the requirements of the Minnesota State Fire Code. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On a facility tour on October 8, 2024, at 12:00 p.m., with owner (O)-A, the surveyor made the following observations of non-compliance with the requirements of the Minnesota State Fire Code: HARDWIRED SMOKE ALARMS	0 780		

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0 780	Continued From page 8 There were wires provided from the building electrical system for hardwired smoke alarms (alarms receiving power from the building electrical system) at the smoke alarms located in the basement hallway near the resident sleeping room, main floor hall near the bathroom, and in the second-floor hall near the resident sleeping rooms. The hardwired smoke alarms were removed and replaced with battery only smoke alarms. Existing hardwired smoke alarms are required to be maintained as installed at the time of construction and interconnected to additional battery-operated alarms so activation of one alarm activates all alarms throughout the facility. SMOKE ALARM MAINTENANCE The battery powered alarm in the second-floor hallway near the resident sleeping rooms was chirping indicating a trouble with the alarm. During the facility tour O-A verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) days	0 780		
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	0 810		

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0 810	Continued From page 9 a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees 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 required content, provide required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 810		

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0 810	Continued From page 10 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 October 8, 2024, at 11:30 a.m., owner (O)-A 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 The licensee provided FSEP, lacked the following: The location and number of resident sleeping rooms were not identified on the posted FSEP evacuation floor plan. Resident sleeping room numbers are required to be included on the evacuation floor plan in order to direct building occupants to an exit in the event of a fire or similar emergency. The available FSEP did not identify specific fire protection actions for residents as evident by not providing procedures for residents to take in this specific facility in the event of a fire or similar emergency in writing in the FSEP. During an interview on October 8, 2024, at 11:40 a.m., O-A stated resident room numbers were not identified on the posted evacuation floor plan and resident actions required during a fire or similar emergency were not included in the FSEP. TRAINING	0 810		

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0 810	Continued From page 11 Record review of the available documentation indicated the licensee failed to provide training to employees on the FSEP upon hire and/or at least twice per year as evident by not providing documentation the required employee training was completed. Record review of the available documentation indicated the licensee failed to provided evacuation training to residents at least once per year as evident by not providing documentation FSEP training was provided to residents as required. During an interview on October 8, 2024, at 11:45 a.m., O-A stated employee FSEP training was completed with drills, but no documentation was available indicating the training was completed. O-A also stated no documentation was available indicating FSEP training was provided to residents as required. DRILLS Record review of the available documentation indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month as evident by providing documentation evacuation drills were completed in February and August of 2024 only. The surveyor stated evacuation drills are required to be completed every other month and twice per shift per year. During an interview on October 8, 2024, at 11:45 a.m., O-A stated documentation was not available indicating evacuation drills were completed every other month and twice per shift per year as	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39269	A. BUILDING: _____ B. WING _____	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUSTOMIZE LIVING LLC	3237 2ND AVENUE SOUTH MINNEAPOLIS, MN 55408

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0 810	Continued From page 12 required. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 970 SS=F	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property for one of one resident (R1). This had the potential to affect the two residents residing in the facility and residents newly admitted. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	0 970		

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0 970	Continued From page 13 R1 was admitted on February 7, 2024, and received services under the licensee's assisted living license. R1's Assisted Living Contract signed February 6, 2024, included the following language indicating a waiver of liability: -"Damage of Injury to Resident of Resident's Property. We were not responsible for any damage or injury suffered by you, your property, your guests, or their property that was not caused by us. We strongly recommend that Resident obtain renter's insurance at an appropriate level to insure against loss of Resident's personal property, as well as related incidental and consequential damages, or such other or additional insurance as Resident considers necessary to protect against injuries and property damage. Our insurance may not cover the loss of your personal property and the incidental and consequential damages arising from the loss of such property. Your personal property includes but is not limited to dentures, glasses, and hearing aids. -Acts of Third Parties. We were not responsible for the actions of, or for any damages, injury or harm caused by the actions of, third parties (such as other residents, guests, intruders, or trespassers) who were not under our direct and actual control. -Resident's Responsibility for Damages. You would be responsible for (a) any loss, property damage (including plumbing problems) or cost of repairs or service caused by your use of the Apartment/Room or the Community facilities, normal wear and tear excepted; (b) any loss or damage to the Apartment/Room or the Community facilities caused by doors or windows left open by you or your guests; (c) all costs or losses we incur because of abandonment of the	0 970		

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0 970	Continued From page 14 Apartment/Room or other violations of this Agreement by you." On October 8, 2024, at 2:20 p.m., owner (O)-A stated they were unaware of the waiver of liability clause in the licensee's contract and the same contract was used for all residents residing within the facility. O-A stated they planned to remove these waiver of liability clauses from current and all new resident contracts going forward. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01290 SS=D	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study	01290		

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01290	Continued From page 15 (BGS) was completed, that was affiliated to the licensee's health facility identification number (HFID) prior to staff providing services for one of three employees (unlicensed personnel (ULP)-D). 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 October 7, 2024, at 1:30 p.m., during the entrance conference, licensed assisted living director and clinical nursing supervisor (LALD/CNS)-B, stated they were aware of the required contents of the employee records and responsible to oversee the employee charts. ULP-D had a hire date of August 14, 2024, and provided direct care and services to residents of the facility under the assisted living licensure. On October 8, 2024, between 9:30 a.m. and 11:00 a.m., ULP-D was observed assisting R1 with medication administration and assisting other residents of the facility with direction and cares. ULP-D's employee record included a Minnesota Department of Human Services (DHS) NetStudy 2.0 clearance form dated August 14, 2024, for HFID 34722 and HFID 35628. ULP-D's record lacked evidence of a completed BGS clearance affiliated with the licensee's HFID 39269.	01290		

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01290	Continued From page 16 On October 8, 2024, at 11:30 a.m., owner (O)-A stated they were aware all staff were required to have the correct HFID affiliation for each place of employment prior to providing care and services to residents of the facility. O-A stated although the licensee was aware of this problem and had contacted DHS, the licensee did not ensure ULP-D had the correct HFID affiliation prior to providing care and services to residents of the facility. The licensee's Recruitment and Hiring Policy, dated October 30, 2023, indicated prior to employment: -For Unlicensed Staff and Licensed Staff who have not completed a fingerprint background study: The Criminal Background Check would be submitted to Minnesota DHS following the step-by-step procedure established by DHS -The administrator or designee was responsible for initiating the criminal background study for new employees -NetStudy 2.0 (or current version) would be used for the background check -The employee would be directed to locations established by DHS to obtain fingerprint scans -Employees would be instructed that photographic identification would be required -Employees/study subjects may have entered their own background study demographic information using the facility identification code provided -For Licensed Staff who completed a fingerprint background study for their State Board license (initiated on 1/1/2018) or for other providers: A criminal background study was not required through the Minnesota Department of Human Services using NetStudy 2.0. -Verification of licensure from the primary source (the appropriate state licensing board) would be	01290		

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01290	Continued From page 17 obtained and the documentation will be maintained in the personnel file -Documentation would be obtained through the OIG related to the employee's eligibility to work -Documentation from the National Sex Offender website may have been accessed. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		

Minnesota Department of Health
Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *10/08/24*
Time: 09:45:00
Report: 1039241321

Food and Beverage Establishment Inspection Report

Location:
Customize Living LLC
3237 2nd Avenue S
Minneapolis, MN55408
Hennepin County, 27

Establishment Info:
ID #: 0043691
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/24

Operator:

Phone #:
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.

4-700 Sanitizing Equipment and Utensils

4-702.11 ***** Priority 1 *****

MN Rule 4626.0900 Sanitize utensils and food contact surfaces of equipment before use, after cleaning.

PER THERMO STICKER TEST, DISHWASHING MACHINE ACHIEVED A MAXIMUM TEMPERATURE OF LESS THAN 150 DEGREES F. REPAIR OR REPLACE DISHWASHING MACHINE AND USE ALTERNATE SANITIZING METHOD IN MEANTIME. SEE GENERAL COMMENTS SECTION BELOW.

Comply By: 10/09/24

4-300 Equipment Numbers and Capacities

4-302.12B ***** Priority 2 *****

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

NO FOOD PROBE THERMOMETER IS ON-HAND. ESTABLISHMENT WILL OBTAIN FOOD PROBE THERMOMETER AND KEEP ON-HAND.

Comply By: 10/18/24

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.

NO TEMPERATURE MEASURING DEVICE FOR MEASURING DISHWASHING MACHINE RINSE TEMPERATURE. KEEP IRREVERSIBLE WATERPROOF THERMOMETER OR COLOR-CHANGE TEST STRIPS ON-HAND.

Comply By: 10/18/24

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

3-304.14B

MN Rule 4626.0285B Wiping cloths used for wiping counters and other equipment surfaces must be held in an approved sanitizing solution and laundered daily.

WET WIPING CLOTH STORED ON EDGE OF SINK BASIN. WIPING CLOTH DISCARDED. ESTABLISHMENT WILL USE SINGLE-USE SANITIZING WIPES. CORRECTED ON SITE.

Corrected on Site

Food and Equipment Temperatures

Process/Item: LACTAID
Temperature: 41 Degrees Fahrenheit - Location: COLD HOLD IN REFRIGERATOR
Violation Issued: No

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

Regarding violation of MN Rule 4626.0900 Sanitize utensils and food contact surfaces of equipment before use, after cleaning: dishes may be cleaned using dishwashing machine, then must be sanitized by dunking in a sanitizer solution prepared in a clean bucket or tub. Prepare sanitizer from chlorine bleach or quaternary ammonium compound. Guidance document included with report.

The inspection was completed with the person in charge and reviewed with MDH nurse evaluator Mary Bruess.

The kitchen is of residential build and should serve food for same-day service only.

The kitchen has wood cabinets with hollow base and laminate countertops, laminate wood floor, painted walls and ceiling. These kitchen finishes and surfaces are clean and well maintained.

The kitchen refrigerator/freezer are of residential grade.

A 2-compartment sink is present in kitchen. 1 compartment is designated for handwashing only.

A residential dishwashing machine is present in the kitchen. During inspection, a run of the dish machine was started with a color-change thermos test strip. Results of the run where shared by person-in-charge via email showing a rinse temperature of less than 150 degrees F.

A supply of single-use gloves is present in kitchen. A supply of single-use sanitizing wipes for food contact surfaces is present in kitchen.

Discussed the following with the person-in-charge: minimum cook temps for animal proteins, food source, foodborne illness symptoms and exclusion of ill employees, avoiding bare hand contact with ready to eat foods, handwashing, sanitizing., all orders on this report.

Type: Full
Date: *10/08/24*
Time: 09:45:00
Report: 1039241321
Customize Living 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 1039241321 of 10/08/24.

Certified Food Protection Manager: Fatumo Abdi

Certification Number: FM111230 Expires: 12/11/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
Charlotte Hall
person-in-charge

Signed: _____
Aron Goodner
Public Health Sanitarian I
Freeman Building
aron.goodner@state.mn.us