DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 16, 2025

Licensee
Flourish Apartments, LLC
9000 Golden Valley Road
Golden Valley, MN 55427

RE: Project Number(s) SL36093016

Dear Licensee:

On September 25, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on July 31, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

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Electronically Delivered

September 3, 2025

Licensee
Flourish Apartments, LLC
9000 Golden Valley Road
Golden Valley, MN 55427

RE: Project Number(s) SL36093016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 31, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH 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. 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 . . ."

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 may be 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;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in

§ 144G.20;
Level 5: a fine of $5,000 per violation, 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 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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 the Department of Health 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

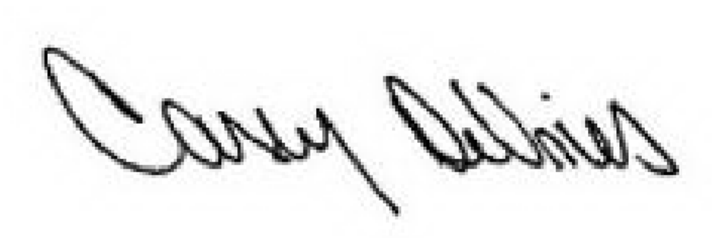
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms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



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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36093	A. BUILDING: _____ B. WING _____	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLOURISH APARTMENTS, LLC	9000 GOLDEN VALLEY ROAD GOLDEN VALLEY, MN 55427

(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: SL36093016-0 On July 28, 2025, through July 31, 2025, 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 97 residents; 32 receiving services under the Assisted Living Facility license. An immediate correction order was identified on July 31, 2025, issued for SL36093016-0, tag identification 1290. The immediate order issued on July 31, 2025, was rescinded on August 1, 2025, and a corrected version was re-issued on August 1, 2025. During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and	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.	

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0 000	Continued From page 1 level remain unchanged.	0 000		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of	0 480		

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0 480	Continued From page 2 a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. 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, but was not likely to cause serious injury, impairment, or death), and is 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report	0 480		

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0 480	Continued From page 3 (FBEIR) dated, July 28, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff 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:	0 680		

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0 680	Continued From page 4 Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 28, 2025, at 1:17 p.m., the surveyor retrieved the licensee's Emergency preparedness plan. The licensee had an abbreviated copy of the EPP located near the front entrance of the facility with a comprehensive version stored in in the licensee's nursing office which had a lockable door. The licensee's written emergency disaster preparedness plan lacked evidence of the following required content: - Policies and procedures to identify at risk population needs like maintaining independence, communication, transportation, supervision, and medical care; - Policies and procedures for volunteers; - Roles under wavier declared by secretary; - Policies and procedures to address the role of facility under a waiver declared by the Secretary in accordance with section 1135 of the Act; - Emergency officials contact information to	0 680		

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0 680	Continued From page 5 include Federal, State, tribal, regional & local emergency management agencies; and - Long term care family notifications. On July 30, 2025, clinical nurse supervisor (CNS)-B stated the licensee's EPP was a joint project between themselves and licensed assisted living director (LALD)-A. Additionally, CNS-B stated they were unaware the licensee's EPP was missing required content, but would work toward ensuring the license's EPP meets standards. The licensee's Emergency and Disaster Preparedness policy dated March 21, 2025, indicated the facility will be prepared to manage emergency and disaster situations, including missing residents through our hazard assessment and emergency planning. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 775 SS=E	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the Minnesota State Fire Code in Minnesota Rules, chapter 7511. This had the potential to directly affect all residents, staff, and visitors.	0 775		

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0 775	Continued From page 6 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: On July 30, 2025, from 9:30 a.m. to 12:30 p.m., the surveyor toured the facility with licensed assisted living director (LALD)-A, maintenance (M)-E and maintenance (M)-F, the surveyor made the following observations of non-compliance with current Minnesota Fire Code provisions: FIRE RESISTANT RATED DOORS - The fire-rated doors at the fifth floor elevator lobby did not close and latch. The door coordinator did not work to allow the doors to close completely when tested. - The fire-rated doors at the fourth floor elevator lobby did not close and latch. Fire-resistant rated doors are required to automatically close and latch to prevent the spread of flame and smoke in the event of a fire or similar emergency in accordance with Minnesota State Fire Code. LALD-A, M-E, and M-F visually verified these deficient findings at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		

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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) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff 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 staff 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	0 810		

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0 810	Continued From page 8 review, the licensee failed to develop the fire safety and evacuation plan with the required content, to provide the required training, and to conduct evacuation drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 30, 2025, licensed assisted living director (LALD)-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's FSEP, Fire, undated, failed to include the following: The FSEP failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine and Extinguish or Evacuate) but failed to include procedures for how staff are to complete each step. The FSEP did not identify specific fire protection actions for residents. The resident handbook included a section for building emergencies. In that section, the procedures for residents was	0 810		

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0 810	Continued From page 9 limited to a shelter-in-place strategy and did not include any information on how to evacuate the building. The FSEP failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included a list of residents identified as needing assistance during an evacuation, but did not include any resident-specific procedures to staff for assisting residents during evacuation. On July 30, 2025, at 2:30 p.m. LALD-A stated they would work on developing a more complete FSEP. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. LALD-A lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. On July 30, 2025, at 2:30 p.m. LALD-A stated they were working with their local fire marshal to schedule a training for staff and residents at the end of August. DRILLS: The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Record review of licensee's evacuation drill log indicated that evacuation drills were not conducted after April 2024. On July 30, 2025, at 2:30 p.m. LALD-A stated	0 810		

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0 810	Continued From page 10 there were no additional documented drills for the facility after April 2024. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 970 SS=C	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 of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect 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: R2 was admitted September 18, 2024, to receive	0 970		

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0 970	Continued From page 11 assisted living services. R2's service plan agreement dated September 18, 2024, indicated R2 received assistance with homemaking services, and laundry. R3 was admitted August 29, 2020, to receive assisted living services. R3's service plan agreement dated March 3, 2025, indicated R3 received assistance with meals, incontinence assistance, physical assistance with activities, assistance with dressing, grooming, hygiene, laundry, and toileting assistance. R5 was admitted May 16, 2023, to receive assisted living services. R5's service plan dated August 7, 2024, indicated R5 received assistance with medication set up. R2's contract dated September 17, 2024, R3's contract dated July 13, 2022, and R5's contract dated May 2, 2023, included the following language: - Page 18, section 10, Miscellaneous Provisions, subsection A., Insurance, "Resident is aware that Landlord and Manager are not responsible for, and will not insure, Resident or Resident's family members', visitors', guests', or invitees' furniture, vehicles, or other personal belongings located on the Premises ("Personal Property"). Landlord requires Resident, and Resident agrees, to obtain and to keep in full force and effect during the entire Term and any extensions, renewal or periods of holdover, a policy of renter's insurance." - Page 21, section 10, Miscellaneous Provisions, subsection Q. Hold Harmless, "You agree to hold harmless Landlord, its owners, management, all of their officers, trustees, staff, and personnel	0 970		

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0 970	Continued From page 12 from any and all claims arising from an injury or illness incurred through natural or normal causes during his life at Landlord." - Page 22, section 10, Miscellaneous Provisions, subsection Q. Liability, "The Resident agrees to be liable and responsible for all obligations herein references, monetary and otherwise, of the Resident and where this Agreement has been executed by a party designated below. Or where a separate Responsible Party Agreement has been executed by a third party, said third party and the Resident shall be jointly and severally liable and responsible for all obligations, monetary and otherwise, of the Resident herein referenced." On July 29, 2025, at 11:22 a.m., licensed assisted living director (LALD)-A stated they had updated the licensee's contract within the last year, but the new contract had not been reissued to the residents. Additionally, LALD-A stated they recalled the licensee's lawyers saying the liability waiver needed to be removed but were not aware new contracts needed to be reissued. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the 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.	01060		

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01060	Continued From page 13 (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 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	01060		

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01060	Continued From page 14 licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, or designated representative, and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation greater than four days, for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 24, 2025, at 4:30 p.m., via email communication, the Regional Ombudsman for Long Term Care stated they had not received any emergency relocations from the licensee for the year of 2025. R3 was admitted August 29, 2020, to receive assisted living services. R3's service plan agreement dated March 3, 2025, indicated R3 received assistance with meals, incontinence assistance, physical assistance with activities, assistance with dressing, grooming, hygiene, laundry, and toileting assistance. R3's diagnosis included acute on chronic diastolic heart failure.	01060		

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01060	Continued From page 15 On July 28, 2025, at 11:29 a.m., during a tour of the facility, the surveyor observed a posting on the door of R3's room indicating oxygen was in use. The surveyor asked if they would be able to observe the oxygen storage within the room. Clinical nurse supervisor (CNS)-B stated R3 was currently out of facility at a transitional care unit (TCU) due to a recent fall. R3's record contained a progress note which indicated R3 was sent to the hospital by the licensee and was transferred to the TCU on July 10, 2025. R3's record lacked evidence the licensee provided the resident or resident's representative a written emergency relocation notice. The record also lacked evidence to indicate the licensee provided the notification to the OOLTC of the emergency relocation greater than four days as required. On July 29, 2025, at 12:19 p.m., licensed assisted living director (LALD)-A stated the licensee had not been completing emergency relocation notices for any residents requiring emergency relocations. LALD-A stated the licensee had been advised on doing this by an interim consulting nurse that had been employed by the licensee. LALD-A stated the licensee currently had an emergency relocation notice process developed and would begin implementing it going forward. The licensee's undated emergency relocation checklist document indicated that upon completing an emergency relocation the facility would deliver the notice to the Office of Ombudsman for Long Term Care if the resident had relocated and not returned to the facility	01060		

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01060	Continued From page 16 within four days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01290 SS=I	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 a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study (BGS) was submitted for seven of eleven employees who officed within an affiliated business that had unrestricted physical access to the assisted living facility (Agent (A)-K, Human Resources (HR)-L, Regional Manager (RM)-M, Director of Compliance (D)-N, and Property Accountant (PA)-O, PA-P, PA-Q). In addition, the licensee failed to ensure a BGS was	01290		

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01290	Continued From page 17 submitted and received in affiliation with the assisted living license for one of eight assisted living employees (receptionist (R)-H). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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: The licensee's layout consisted of a five-story apartment building. The licensee's administration and nursing offices were placed directly off the main entrance of the facility. There was an additional office space located at the very end of the hallway on the ground floor of the facility. This office space was accessed from the licensed facility by a door with a key fob locking mechanism. The signage next to the door on the Assisted Living side indicated "The Schuett Companies, Inc." On July 30, 2025, at 11:30 a.m., during a tour the engineering surveyor observed the additional office suite had a dedicated entrance from the parking lot but also had a back door into the assisted living facility. Maintenance (M)-E stated the staff who officed within the additional office space were employees of the development company that built, owned, and operated the building. The licensee's employee roster indicated R-H had a hire date of March 24, 2014.	01290		

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01290	Continued From page 18 On July 30, 2025, at 1:28 p.m., R-R provided the surveyor with a NETStudy 2.0 (web-based system used to submit BGS to the Department of Human Services (DHS)) Final Registry Results form (not a background study clearance letter) for R-H. R-H's Final Registry Results form dated July 1, 2020, was affiliated to the licensee's sister company with a health facility identification number (HFID) 27792. On July 30, 2025, at 1:46 p.m., while reviewing the licensee's NETStudy 2.0 roster, licensed assisted living director (LALD)-A demonstrated they did not have an active background study for R-H under HFID 36093. Additionally, LALD-A demonstrated they only had access to background checks affiliated to the licensee's HFID 36093. They were not the same Sensitive Information Person (SIP) for the HFID R-H's BGS was run under (27792). On July 30, 2025, at 1:48 p.m., vice president of operations (VP)-G stated a key fob was needed to obtain access to the additional office space within the facility, but no key would be needed to go from the office space into the assisted living facility. VP-G stated all staff within the offices could hypothetically obtain access to the assisted living facility. On July 31, 2025, at 10:50 a.m., LALD-A stated they were responsible for the maintenance of the licensee's NetStudy 2.0 background study roster. Additionally, LALD-A reiterated they did not have access to the background study roster of the licensee's sister company HFID 27792. On July 30, 2025, at 3:32 p.m., LALD-A stated background checks for new employees were	01290		

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01290	Continued From page 19 completed upon hire. LALD-A stated anyone that had contact with residents was required to have a background check with the facility. On July 30, 2025, at 4:21 p.m., in an email message, LALD-A provided a list 11 names and titles of the staff who worked within the additional office space. LALD-A indicated an asterisk next to the names for four of the eleven staff who had active background checks affiliated with the licensee, which the surveyor was able to be verify upon review of the licensee's NetStudy 2.0 background study roster. Seven of the eleven staff did not have an asterisk next to their name, implying there was no NetStudy 2.0 background check on file for employees. On July 31, 2025, at 11:21 a.m., in an email message, VP-G stated, "As I communicated yesterday, Schuett staff, in the Schuett offices, that do not have asterisks next to their name, do not have NetStudy background checks." On July 31, 2025, at 2:03 p.m., in an email message, VP-G stated the licensee and the affiliated business office [The Schuett Companies, Inc.] were owned by the same trust. On August 1, 2025, at 9:27 a.m., LALD-A verified via email R-H worked during the survey on July 29, 2025, from 9:23 a.m., to 12:02 p.m. The licensee's Employee Background Check policy dated March 14, 2023, indicated all employees; as well as contractors, and regularly scheduled volunteers of the facility with direct resident contact will undergo a background study through DHS. Only those with satisfactory results will continue to work with the facility and its residents.	01290		

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01290	Continued From page 20 TIME PERIOD FOR CORRECTION: Immediate	01290		
01460 SS=F	144G.63 Subdivision 1 Orientation of staff and supervisors (a) All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility, except as provided in paragraph (b). (b) A staff person is not required to repeat the orientation required under subdivision 2 if the staff person transfers from one licensed assisted living facility to another facility operated by the same licensee or by a licensee affiliated with the same corporate organization as the licensee of the first facility, or to another facility managed by the same entity managing the first facility. The facility to which the staff person transfers must document that the staff person completed the orientation at the prior facility. The facility to which the staff person transfers must nonetheless provide the transferred staff person with supplemental orientation specific to the facility and document that the supplemental orientation was provided. The supplemental orientation must include the types of assisted living services the staff person will be providing, the facility's category of licensure, and the facility's emergency procedures. A staff person cannot transfer to an assisted living facility with dementia care without satisfying the additional training requirements under section 144G.83.	01460		

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01460	Continued From page 21 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received orientation to assisted living licensure requirements and regulations before providing assisted living services to residents for one of three employees (clinical nurse supervisor (CNS)-B). 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 the potential to affect a large portion or all of the residents). The findings include: CNS-B was hired on January 13, 2025, to provide assisted living services and clinical oversite. CNS-B's employee record contained a record of orientation which had been completed under the licensee's prior comprehensive homecare license. The orientation occurred prior to the licensee's conversion to assisted living licensure. On July 30, 2025, at 11:32 a.m., CNS-B stated they had worked with the licensee as a caregiver in 2020 but had stopped working for the licensee from 2023 to 2025. CNS-B stated when they returned to working for the licensee, they oriented under an interim nurse and was not aware additional orientation would need to be	01460		

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01460	Continued From page 22 completed. The licensee's Assisted Living Orientation - All Staff policy dated March 21, 2025, indicated all assisted living employees must complete an orientation to assisted living facility licensing requirements and regulations before providing services to residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01460		
01530 SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until	01530		

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01530	Continued From page 23 this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure required dementia care training was completed for one of three employees (clinical nurse supervisor (CNS)-B), and failed to ensure two hours of initial mental illness and de-escalation training were conducted within 160 hours of providing direct care to residents for two of two direct care staff (CNS-B, 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 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).	01530		

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01530	Continued From page 24 The findings include: CNS-B CNS-B was hired on January 13, 2025, to provide assisted living services and clinical oversite. CNS-B's employee record contained a record of dementia training which had been completed under the licensee's prior comprehensive homecare license. The training consisted of 7.75 hours of dementia training with the most recent being June 10, 2020. The dementia training occurred prior to the licensee's conversion to assisted living licensure from a previous time of employment. CNS-B's record lacked 8 hours or required dementia care training under the licensee's current assisted living licensure and two hours of initial mental illness and de-escalation training. ULP-D ULP-D was hired June 14, 2022, to provide assisted living services. ULP-D's employee record lacked two hours of initial mental illness and de-escalation training. On July 30, 2025, at 11:32 a.m., CNS-B stated they had worked with the licensee as a caregiver in 2020 but had stopped working for the licensee from 2023 to 2025. CNS-B stated when they returned to working for the licensee, they oriented under an interim nurse and was not aware additional orientation would need to be completed. On July 30, 2025, at 11:41 a.m., CNS-B showed the surveyor that ULP-D had not yet started their	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36093	A. BUILDING: _____ B. WING _____	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLOURISH APARTMENTS, LLC	9000 GOLDEN VALLEY ROAD GOLDEN VALLEY, MN 55427

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01530	Continued From page 25 assigned mental health training on ULP-D's Educare (online training program) transcript page. CNS-B stated the education was assigned but had not yet been completed. The licensee's Demetia Training policy dated March 21, 2025, indicated assisted living staff will receive required training on dementia care during orientation and annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01650 SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01650	Continued From page 26 authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included the required content for one of four residents (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 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: R5 was admitted to the licensee on May 16, 2023, to receive assisted living services. R5's diagnoses included essential hypertension, chronic atrial fibrillation, and restless leg syndrome. R5's untitled document dated August 7, 2024, which contained information required to be included in resident service plans and was utilized by the licensee as a service plan lacked the following required components of service plans: - the names and contact information of persons	01650		

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01650	Continued From page 27 the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and - the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. On July 29, 2025, at 11:11 a.m., clinical nurse supervisor (CNS)-B stated R5 did not have any new service plans on file. Additionally, CNS-B stated the licensee's new service plan templates would cover the missing items noted in R5's service plan. The licensee's Service Plan Contents policy dated March 21, 2025, indicated the service plan would contain a contingency plan that includes the names and contact information of persons the resident wishes to have notified in an emergency, names and contact information of persons the resident wishes to have notified if there is a significant adverse change in the resident's condition, and circumstances in which emergency medical services are not to be summoned. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse,	01730		

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01730	Continued From page 28 advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing	01730		

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01730	Continued From page 29 medication management. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and maintain a current individualized medication management record for each resident to include all required content for one of four residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: R2 was admitted to the licensee on September 18, 2024, to receive assisted living services. R2's diagnoses included type 2 diabetes, repeated falls, metabolic encephalopathy, chronic kidney disease, obstructive sleep apnea, nonrheumatic aortic stenosis, constipation, hyperlipidemia, major depressive disorder, and unspecified protein-calorie malnutrition. R2's service plan dated September 18, 2024, indicated R2 received services to include medication administration. R2's Recert Assessment dated July 15, 2025, which was utilized as the licensee's 90-day assessment form and contained R2's medication	01730		

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	36093	A. BUILDING: _____ B. WING _____	07/31/2025

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01730	Continued From page 30 management assessment lacked procedures for staff to notify an RN when problems arose. On July 30, 2025, at 3:16 p.m., stated they believed the missing components identified in R2 medication management plan would be built into the licensee's updated service plan template which would be used by the licensee going forward. The licensee's Medication, Treatment, and Therapy Service s policy dated March 14, 2023, indicated medication management plans would contain procedures for notifying a registered nurse or appropriate licensed health professional when a problem arose with medication management services. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances.	01910		

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	36093	A. BUILDING: _____ B. WING _____	07/31/2025

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01910	Continued From page 31 (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include the date of disposition and names of staff and other individuals involved in the disposition for one of one discharged residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R1 discharged from the licensee on April 2, 2025. R1's record lacked documentation of the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition.	01910		

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01910	Continued From page 32 On July 30, 2025, at 10:53 a.m., clinical nurse supervisor (CNS)-B stated the licensee did not have a medication disposition form on file or available for use, but was able to reach out to an affiliated facility to obtain a disposition form and would begin implementing the process for future discharges. The licensee's Disposition or Disposal of Medication policy dated April 3, 2025, indicated the licensee would document in the resident's record the name of the person to whom the medications were given, the time and date, the name of each medication and the amount of medication remaining. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Flourish Apartments LLC
9000 Golden Valley Road
Golden Valley, MN 55427
Hennepin County
Parcel:

Phone:

License Info

License: HFID 36093

Risk:
License:
Expires on:
CFPM:
CFPM #: ; Exp:

Inspection Info

Report Number: F7994251065
Inspection Type: Full - Single
Date: 7/28/2025 Time: 11:43:31 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 1
Total Priority 2 Orders: 1
Total Priority 3 Orders: 2
Delivery: Emailed

New Order: 2-100 Supervision
2-102.12AMN *Priority Level: Priority 3 CFP#: 2*
MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.
COMMENT: NO CURRENT MINNESOTA CFPM WAS FOUND ON SITE. INFORMATION PROVIDED IN EMAIL.
Comply By: 7/28/2025 Originally Issued On: 7/28/2025

! **New Order: 3-300B Protection from Contamination: cross-contamination, eggs**
3-302.11A(1) *Priority Level: Priority 1 CFP#: 15*
MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.
COMMENT: RAW MEAT FOUND STORE ABOVE READY TO EAT FOODS ON A SPEED RACK IN WALK IN COOLER. STAFF MOVED RAW FOODS BELOW READY TO EAT FOODS.
Comply By: 7/28/2025 Originally Issued On: 7/28/2025

New Order: 3-300C Protection from Contamination: equipment/utensils, consumers
3-305.11A *Priority Level: Priority 3 CFP#: 39*
MN Rule 4626.0300A Store all food in a clean, dry location; where it is not exposed to splash, dust or other contamination; and at least 6 inches above the floor.
COMMENT: BOXES FOUND STORED ON THE WALK IN FREEZER FLOOR. ENSURE ITEMS ARE STORED AT LEAST 6 INCHES OFF THE FLOOR.
Comply By: 7/28/2025 Originally Issued On: 7/28/2025

New Order: 4-300 Equipment Numbers and Capacities
4-302.13B *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.
COMMENT: NO TEMPERATURE MEASURING DEVICE OR TEMPERATURE TEST STRIPS WERE FOUND ON SITE. ENSURE THESE ARE AVAILABLE AT ALL TIMES.
Comply By: 7/28/2025 Originally Issued On: 7/28/2025

Food & Beverage General Comment

INSPECTION CONDUCTED IN THE PRESENCE OF HRD STAFF AND FINDINGS SHARED AT THE END OF INSPECTION.

WILL EMAIL SUPPORTING DOCUMENTS AND LINKS TO HRD STAFF AT THE END OF THE DAY.

TEMPERATURES:

COOK LINE
CHEESE 41
CREAM 41

HOT HOLDING
BEEF 144
MASHED POTATOES 157
CARROTS 152

WALK IN
COLE SLAW 38
TUNA 36
EGG 40

SANITIZERS:
DISHWASHER 165 F

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Metro District Office inspection report number F7994251065 from 7/28/2025

Crystal Elva

Alicia Witherspoon
Agent

Crystal Elva, REHS, MS, BS
Public Health Sanitarian 3
651-201-3981
crystal.elva@state.mn.us

Minnesota (MDH) Version
EH Manager; RPT: F7994251065

Food Establishment Inspection Report

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

No. of Risk Factor/Intervention/Violations	2	Date: 7/28/2025
No. of Repeat Risk Factor/Intervention/Violations		Time: 11:43:31 AM
Score (optional)		Dur: min

Establishment:	Address:	City/State:	Zip:	Phone:
Flourish Apartments LLC	9000 Golden Valley Road	Golden Valley, MN	55427	
License/Permit #:	**Permit Holder:**	**Purpose of Inspection:**	**Est. Type:**	**Risk Category:**
HFID 36093		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Designated compliance status (IN, OUT, N/O, N/A) for each numbered item

IN=in compliance **OUT**=not in compliance **N/O**=not observed **N/A**=not applicable

Mark "X" in appropriate box for COS and/or R

COS=corrected on-site during inspection **R**=repeat violation

	Compliance Status		COS	R
	Supervision			
1	IN	Person in charge present, demonstrate knowledge and performs duties		
2	OUT	Certified Food Protection Manager		
	Employee Health			
3	IN	knowledge, responsibiities, and reporting		
4	IN	Proper use of restriction and exclusion		
5	IN	Response to vomiting, diarrheal events		
	Good Hygienic Practices			
6	IN	Proper eating, tasting, drinking, tobacco use		
7	IN	No discharge from eyes, nose, and mouth		
	Preventing Contamination by Hands			
8	IN	Hands clean and properly washed		
9	IN	No bare hand contact with RTE foods, alternatives		
10	IN	Adequate handwashing sinks supplied and access		
	Approved Source			
11	IN	Food obtained from approved source		
12	N/O	Food Received at proper temperature		
13	IN	Food in good condition, safe & unadulterated		
14	N/A	Records available: shellstock tags, parasite dest.		
	Protection From Contamination			
15	OUT	Food separated and protected		
16	IN	Food-contact surfaces; cleaned & sanitized		
17	IN	Proper Disposition of returned, previously served, reconditioned,& unsafe food		

	Compliance Status		COS	R
	Time/Temperature Control for Safety			
18	N/O	Proper cooking time & temperatures		
19	N/O	Proper reheating procedures for hot holding		
20	N/O	Proper cooling time and temperature		
21	IN	Proper hot holding temperatures		
22	IN	Proper cold holding temperatures		
23	IN	Proper date marking & disposition		
24	N/A	Time as public health control;procedures & record		
	Consumer Advisory			
25	N/A	Consumer advisory provided for raw or undercooked foods		
	Highly Susceptible Populations			
26	IN	Pasteurized foods used; prohibited foods not offered		
	Food/Color Additives and Toxic Substances			
27	N/A	Food additives; approved & properly used		
28	IN	Toxic substances properly identified;stored;used		
	Conformance with Approved Procedures			
29	N/A	Compliance with variance, specialized processes & HACCP plan		

Risk factors are improper practices or procedures identified as the most prevalent contributing factors of foodborne illness or injury. Public Health Interventions are control measures to prevent foodborne illness or injury

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" or OUT in box if numbered item is **not** in compliance Mark "X" in appropriate box for COS and/or R **COS**=corrected on-site during inspection **R**=repeat violation

			COS	R
		Safe Food and Water		
30	IN	Pasteurized eggs used where required		
31		Water & ice from approved source		
32	N/A	Variance obtained for specialized processing methods		
		Food Temperature Control		
33		Proper cooling methods used; adequate equipment for temperature control		
34	N/O	Plant food properly cooked for hot holding		
35	IN	Approved thawing methods used		
36		Thermometers provided & accurate		
		Food Identification		
37		Food properly labeled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present; no unauthorized person		
39	X	Contamination prevented during food prep, storage, & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
		Proper Use of Utensils		
43		In-use utensils; Properly stored		
44		Utensils, equipment & linens; properly stored, dried, handled		
45		Single-use & single-service articles, properly stored and used		
46		Gloves used properly		
		Utensils, Equipment and Vending		
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48	X	Warewashing facilities: installed, maintained, used; test strips		
49		Non-food contact surfaces clean		
		Physical Facilities		
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities; properly constructed, supplied & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing and plan review		

Person in Charge (signature)

Inspector (signature) Crystal Elva

Follow-up: Follow-up Date: