Electronically Delivered

April 3, 2025

Licensee
Paradise Care Homes LLC
7709 Unity Avenue North
Brooklyn Park, MN 55443

RE: Project Number(s) SL34668016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 30, 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 . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

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

The correction order documentation should include the following:

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

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

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

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
	34668	A. BUILDING: _____ B. WING _____	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARADISE CARE HOMES LLC	7709 UNITY AVENUE NORTH BROOKLYN PARK, MN 55443

(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 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: SL34668016-0 On January 27, 2024, through January 30, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were five residents, all of whom received services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (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 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	0 480		

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0 480	Continued From page 2 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 (FBEIR) dated January 27, 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	0 480		

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0 480	Continued From page 3 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: Based on observation, interview, and record review the licensee failed to have a written emergency preparedness plan (EPP) with all the required content and failed to post an EPP prominently. This had the potential to affect all five residents receiving services under the	0 680		

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0 680	Continued From page 4 assisted living license. 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: The licensee's EPP last reviewed on July 27, 2024, lacked evidence of the following required content: - EPP program patient population; - subsistence needs for staff and patients; - procedures for tracking of staff and patients; - policies and procedures for volunteers; - methods for sharing information; - sharing information on occupancy/needs; and - LTC family notifications. On January 28, 2025, at 10:40 a.m., licensed assisted living director (LALD)-C stated the licensee was still working on their EPP to meet the requirement. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated the licensee would have an identified plan in place to ensure 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	0 680		

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0 680	Continued From page 5 (21) days	0 680		
0 775 SS=F	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 Minnesota State Fire Code, under Minnesota Rules Chapter 7511. 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 January 29, 2025, at 1:50 p.m., the surveyor toured the facility with licensed assisted living director (LALD)-C. During the tour, the surveyor observed the following: 1. In occupied resident sleeping room 4, the egress window was obstructed by the storage of personal items in front of the window. Egress windows must be accessible at all times and maintained free of obstruction. During the tour interview, LALD-C verified the above listed	0 775		

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0 775	Continued From page 6 observation. 2. In the outdoor designated smoking area, a plastic container was used for the disposal of smoking materials. Burnt cigarettes had been disposed of on the ground in the yard. Improper disposal of burnt smoking materials creates a fire hazard. During the tour interview, LALD-C verified the above listed observations. 3. An orange bucket containing burnt cigarettes was stored in the garage. During the tour interview, LALD-C stated this bucket belonged to the person who was currently onsite making repairs and was not used by the facility for smoking material disposal. 4. The only egress window for unoccupied resident sleeping room 1 exited into the pool area enclosed by a fence. The egress path to the public right of way must be maintained unobstructed. During the tour interview, LALD-C verified the location of the outdoor pool enclosed by a fence. TIME PERIOD FOR CORRECTION: Two (2) days	0 775		
0 800 SS=E	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.	0 800		

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0 800	Continued From page 7 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect more than a limited number of 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 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 January 29, 2025, at 1:50 p.m., the surveyor toured the facility with licensed assisted living director (LALD)-C. During the tour, the surveyor observed the following: 1. An uncovered swimming pool in the backyard was in disrepair and a tarp had collapsed into the pool basin. The uncovered empty pool creates a safety risk to the building occupants in the event of an evacuation from the egress window in resident room 1. Public swimming pools that are accessible must either be provided with a lockable pool cover or the pool must be removed and the excavated area filled in. When pool covers are installed, the cover must comply with safety standards to prevent people from accessing the pool basin. During the tour	0 800		

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0 800	Continued From page 8 interview, LALD-C verified the pool was in disrepair. 2. Personal items were stored outside on the ground under the egress window for occupied resident sleeping room 2. During the tour interview, LALD-C verified the area under the egress window was used for storage. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) 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	0 810		

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0 810	Continued From page 9 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 review, the licensee failed to develop the fire safety and evacuation plan with required content, make the plan readily available, and 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 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 January 29, 2025, at 1:50 p.m., the surveyor toured the facility with licensed assisted living director (LALD)-C. During the tour, the surveyor observed the fire safety and evacuation plan was not located in a central location for all staff accessibility. During the tour interview, LALD-C stated the FSEP was kept in the locked med cabinet. On January 29, 2025, LALD-C provided documents on the fire safety and evacuation plan	0 810		

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0 810	Continued From page 10 (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The FSEP failed to accurately identify the location and number of resident sleeping rooms and the emergency exits for the facility on the posted floor plans. Two copies of the basement floor plan were posted and the location of resident sleeping rooms 5 and 6 did not match. Resident sleeping room identifiers must be accurate on the FSEP floor plan to provide efficient communication for exiting in the event of a fire or similar emergency. The posted FSEP floor plan had arrows leading to the front and side doors. Exit labels were not included on the floor plan. The FSEP floor plan failed to clearly identify the location of the emergency exits for the facility. Exit labels are required to be included on the floor plan in order to direct occupants to the exits in the event of an emergency. The licensee FSEP included a fire safety policy dated May 31, 2022. This FSEP policy was a template from a third-party provider and had not been developed for use at this facility. The FSEP included standard employee procedures, but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The employee actions were limited to the RACE (Remove, Alarm, Confine, Extinguish/Evacuate) acronym. The FSEP did not identify specific fire protection procedures necessary for residents evident by limited instructions to stoop or crawl to avoid smoke.	0 810		

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0 810	Continued From page 11 A fire safety training binder inaccurately referenced smoke compartments and a defend-in-place strategy in a building that did not have any fire resistant construction or life safety systems. The FSEP included standard resident evacuation procedures, but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents evident by no procedures in the plan. During an interview on January 29, 2025, at 3:15 p.m., LALD-C verified the FSEP required revision. TRAINING Record review indicated the licensee failed to provide fire safety and evacuation training to residents at least once per year evident by the lack of documentation to support the training had been completed. Training records were provided but the names of the residents who participated was not recorded. During an interview on January 29, 2025, at 3:15 p.m., LALD-C verified the training records did not include the required documentation. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month evident by review of fire drill reports lacking the required documentation. Six fire drills were completed in 2024. The names of the employees who had participated in the drills were not recorded on any of the fire drill reports. During an interview on January 29, 2025, at 3:15	0 810		

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0 810	Continued From page 12 p.m., LALD-C verified the evacuation fire drill records did not include the required documentation. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences,	01370		

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01370	Continued From page 13 cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for two of two employees (unlicensed personnel (ULP)-B, ULP-E). 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: ULP-B started employment with the licensee on July 29, 2024, to provide direct care services to residents. ULP-E started employment with the licensee on March 1, 2023, to provide direct care services to residents. ULP-B and ULP-E's training record lacked the following required content:	01370		

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01370	Continued From page 14 COMPETENCY EVALUATIONS: - hair care and bathing; - care of teeth, gums, and oral prosthetic devices; - care and use of hearing aids; - dressing and assisting with toileting; and - standby assistance techniques and how to perform them. On January 28, 2024, at 11:40 a.m., licensed assisted living director (LALD)-C stated the licensee was not aware the staff were missing any assigned training. When the surveyor asked about the missing training and competencies for ULP-B and ULP-E, LALD-C stated they would have to go through all the employee files to ensure all required training was available. The licensee's Orientation and Training policy dated August 23, 2022, indicated prior to the delegation of services the registered nurse (RN) must make certain the unlicensed personnel are trained in the proper methods to perform the tasks or procedures for each client and are able to demonstrate the ability to competently follow the procedures and perform the tasks. The policy also indicated a training record, kept in employee records, will be retained for each employee who performs direct home care services to track compliance with training requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and	01380		

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01380	Continued From page 15 competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services for two of two employees (unlicensed personnel (ULP)-B, ULP-E). 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: ULP-B started employment with the licensee on July 29, 2024, to provide direct care services to residents.	01380		

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01380	Continued From page 16 ULP-E started employment with the licensee on March 1, 2023, to provide direct care services to residents. ULP-B and ULP-E's training record lacked the following required content: COMPETENCY EVALUATIONS: - reading and recording temperature, pulse, and respirations of the resident; and - range of motioning and positioning. On January 28, 2024, at 11:40 a.m., licensed assisted living director (LALD)-C stated the licensee was not aware the staff were missing any assigned training. When the surveyor asked about the missing training and competencies for ULP-B and ULP-E, LALD-C stated they would have to go through all the employee files to ensure all required training was available. The licensee's Orientation and Training policy dated August 23, 2022, indicated prior to the delegation of services the registered nurse (RN) must make certain the unlicensed personnel are trained in the proper methods to perform the tasks or procedures for each client and are able to demonstrate the ability to competently follow the procedures and perform the tasks. The policy also indicated a training record, kept in employee records, will be retained for each employee who performs direct home care services to track compliance with training requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		

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01470	Continued From page 17	01470		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this	01470		

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01470	Continued From page 18 subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. 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 facility licensing requirements and regulations prior to providing services for one of two employees (unlicensed personnel (ULP)-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) 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:	01470		

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01470	Continued From page 19 ULP-B started employment with the licensee on July 29, 2024, to provide assisted living services. ULP-B's record lacked orientation to assisted living facility licensing requirements and regulations to include: - review of provider's policies and procedures. On January 28, 2025, at 2:55 p.m., licensed assisted living director (LALD)-C stated all employees undergo orientation training before starting to provide resident services. When the surveyor asked about the missing topics, LALD-C stated some employee records were in the main office off-site and that they will provide it. But by the exit time the licensee had not provided the requested record. The licensee's Orientation of staff and supervisors & content policy dated August 23, 2022, indicated all staff providing direct services will receive orientation and training on topics required for assisted living organizations. Also indicated newly hired unlicensed personnel will receive orientation and training on topics required by Minnesota statutes and rules for assisted living organizations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training	01500		

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01500	Continued From page 20 may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:	01500		

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01500	Continued From page 21 (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received at least eight (8) hours of training for each 12 months of employment for one of two employees (unlicensed personnel (ULP)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-E started employment with the licensee on March 1, 2023, to provide direct care services to residents. ULP-E's record indicated they had completed five hours of annual training in the following topics all completed July 20, 2024:	01500		

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01500	Continued From page 22 - training on reporting of maltreatment of vulnerable adults - one hour; - review of infection control techniques review of infection control techniques - one hour; - effective approaches to use to problem solve when working with a resident's challenging behaviors - one hour; and - the principles of person-centered planning and service delivery - one hour. ULP-E's record lacked annual training in the following required topic(s): - review of provider's policies and procedures. On January 28, 2025, at 11:50 a.m., licensed assisted living director (LALD)-C stated the licensee had completed annual training but was not sure how ULP-E's file was missing the required hours and topics. LALD-C also stated they had recently audited employee files and completed training for those who were missing any required topics. The licensee's Annual Required Staff Training policy dated August 1, 2021, indicated all staff that perform direct care services at Comfort Care Center will complete at least eight (8) hours of annual training for each 12 months of employment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted	01760		

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01760	Continued From page 23 living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were transcribed accurately and administered as prescribed for one of one resident (R2) with an insulin injection. 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: R2's diagnoses included type II diabetes, high blood pressure, depression, anxiety, congestive heart failure, and history of traumatic brain injury. R2's service plan dated December 21, 2021, indicated R2 received the following services: monitoring and reassessments, daily assistance	01760		

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01760	Continued From page 24 with dressing, medication reminders, medication administration, blood sugar checks, laundry, housekeeping and linen change, and behavior management. On January 28, 2025, at 8:13 a.m., the surveyor observed unlicensed personnel (ULP)-F prepare and hand over insulin injection supplies to R2 for self-administration. R2 dialed on the insulin pen 34 units and showed to the surveyor before completing self-administration. R2's medication administration record (MAR) for January 2025 indicated Lantus inject 30 units subcutaneously in the morning. R2's provider order dated July 3, 2024, indicated Lantus Solostar 100 unit/milliliter subcutaneous solution inject 34 units daily. On January 30, 2025, at 11:10 a.m., clinical nurse supervisor (CNS)-A stated they were aware the right dose should be 34 units. CNS-A also stated the dosage was changed recently and that they were aware the MAR had not been updated to reflect the right dosage. The licensee's Medication error policy dated August 23, 2022, indicated the registered nurse will review dosage weekly to ensure medications are administered correctly. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01820 SS=D	144G.71 Subd. 13 Prescriptions	01820		

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01820	Continued From page 25 There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a written or electronically recorded prescription was obtained for one of two 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) 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's diagnoses included type II diabetes, high blood pressure, depression, anxiety, congestive heart failure (CHF), and post traumatic brain injury (TBI). R2's service plan dated December 21, 2021, indicated R2 received the following services: monitoring and reassessments, daily assistance with dressing, medication reminders, medication administration, blood sugar checks, laundry, housekeeping and linen change, and behavior management. R2's medication administration record (MAR) for January 2025, indicated R2 received the following medications: amphetamine 10 milligrams (mg)	01820		

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01820	Continued From page 26 take one tablet by mouth daily, amphetamine 30 mg take one tablet by mouth twice daily, gabapentin 600 mg take two tablets by mouth daily, clonazepam 0.5 mg take one tablet daily, clonazepam 0.5 mg take one tablet daily as needed, duloxetine dr 30 mg capsule take one capsule by mouth daily, duloxetine dr 60 mg capsule take one capsule by mouth daily, metoprolol er 50 mg tablet take one tablet by mouth daily, furosemide 20 mg tablet take three tablets by mouth daily, metformin 1000 mg er take two tablets by mouth daily, Jardiance 10 mg tablet take one tablet by mouth daily, and lisinopril 20 mg tablet take one tablet by mouth daily. R2's record lacked a written or electronically recorded prescription for the following medications: - amphetamine 10 mg take one tablet by mouth daily; and - amphetamine 30 mg take one tablet by mouth twice daily. On January 28, 2025, at 12:50 p.m., licensed assisted living director (LALD)-C stated they had all the signed orders in their office, and they would send them to the surveyor. However, by the survey exit, they had not provided the orders. On January 30, 2025, at 11:30 a.m., clinical nurse supervisor (CNS)-A stated they believed they had all the signed orders for R2 medications. Also, CNS-A stated they needed time to find the signed orders from their offsite office location. The licensee's Medication Orders policy dated August 12, 2022, indicated when a written or electronic prescription is received, it must be communicated to the registered nurse in charge and recorded or placed into the resident's clinical	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34668	A. BUILDING: _____ B. WING _____	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01820	Continued From page 27 record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure time sensitive medications were labeled with the date opened for one of one resident (R2) with insulin pens. 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 January 28, 2025, at 8:13 a.m., the surveyor observed unlicensed personnel (ULP)-F prepare and hand over undated insulin injection pen and supplies to R2 for self-administration. R2 dialed	01890		

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	34668	A. BUILDING: _____ B. WING _____	01/30/2025

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01890	Continued From page 28 on the insulin pen 34 units and showed to the surveyor before completing self-administration. On January 28, 2025, at 8:30 a.m., the surveyor observed in R2's medication cabinet two undated insulin glargine pens. On January 28, 2025, at 12:10 p.m., clinical nurse supervisor (CNS)-A stated insulin pens should be labeled with an open date on the first time before use and discarded after 28 days thereafter. CNS-A stated they were not aware the staff were not labeling the pens as instructed. The Lantus manufacturer's how to use your Lantus Solostar pen instructions indicated after 28 days, throw your opened Lantus pen away even if it still has insulin in it. The manufacturer label on the pen indicated to use within 28 days after opening. The licensee's Medication-Prescription Drugs & Prohibition policy dated August 1, 2021, indicated prescription drugs would be kept in the original container bearing the original prescription label with legible information that included the expiration or beyond use date of a time dated drug. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of	01940		

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	34668	A. BUILDING: _____ B. WING _____	01/30/2025

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01940	Continued From page 29 ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop a treatment management plan to include all required content for one of one resident (R2) who received a treatment. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34668	A. BUILDING: _____ B. WING _____	01/30/2025

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01940	Continued From page 30 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: R2's diagnoses included traumatic brain injury (TBI), post-traumatic stress disorder (PTSD), anxiety, congestive heart failure (CHF), and diabetes mellitus type 2 (DM2). R2's Service Plan dated December 21, 2021, indicated R2 received assistance with daily supervision of dressing, verbal medication reminders, medication administration, meals, blood glucose checks, hands on assistance with mobility, laundry, housekeeping, and daily safety checks. R2's medication administration record (MAR) dated January 2025, indicated R2 received Lantus injection 30 units every morning. R2's provider orders signed January 17, 2024, included Libre 14-day reader for blood glucose monitoring. R2's record lacked a treatment management plan to include: - documentation of specific resident instructions relating to the treatments or therapy administration; - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and - any resident-specific requirements relating to	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01940	Continued From page 31 documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On January 28, 2024, at 12:10 p.m., clinical nurse supervisor (CNS)-A stated R2 refused to allow the staff to check their blood sugar level readings. CNS-A also stated R2 had lost their meter recently and their insurance could not allow them to have a new one yet. When the surveyor asked how CNS-A was ensuring R2's blood sugar levels were within ranges to receive insulin, CNS-A stated they always ensure R2 eats before receiving insulin administration. Further, CNS-A stated they had informed the provider via phone conversation but they had not written a corresponding note for the same. The licensee's Treatment &Therapy Management Plan dated August 1, 2021, indicated the individualized treatment and therapy management record would include the content listed above. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01960 SS=F	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must	01960		

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01960	Continued From page 32 include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to document treatment administration for one of one resident (R2) with blood glucose monitoring. 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: R2's diagnoses included traumatic brain injury (TBI), post-traumatic stress disorder (PTSD), anxiety, congestive heart failure (CHF), and diabetes mellitus type 2 (DM2). R2's Service Plan dated December 21, 2021, indicated R2 received assistance with daily supervision of dressing, verbal medication reminders, medication administration, meals, blood glucose checks, hands on assistance with mobility, laundry, housekeeping, and daily safety checks. On January 28, 2025, at 8:13 a.m., the surveyor observed unlicensed personnel (ULP)-F prepare	01960		

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01960	Continued From page 33 and hand over insulin injection supplies to R2 for self-administration. R2's medication administration record (MAR) dated January 2025, indicated R2 received Lantus injection 30 units every morning. R2's provider orders signed January 17, 2024, included Libre 14-day reader for blood glucose monitoring daily. R2's record lacked documentation for blood glucose monitoring daily to prevent possible complications or adverse reactions, or document the reason why it was not done and any follow-up procedures that were provided to meet the resident's needs. On January 28, 2024, at 12:10 p.m., clinical nurse supervisor (CNS)-A stated the R2 refused to allow the staff to check their blood sugar level readings. CNS-A also stated R2 had lost their meter recently and their insurance could not allow them to have a new one yet. When the surveyor asked how CNS-A was ensuring R2's blood sugar levels were within ranges to receive insulin, CNS-A stated they always ensure R2 eats before receiving insulin administration. Further, CNS-A stated they had informed the provider via phone conversation, but they had not written a corresponding note for the same. The licensee's Treatment &Therapy Management Plan dated June 1, 2022, indicated staff would document each task immediately after that task was performed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01960	Continued From page 34 days	01960		

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

Type: Full
Date: *01/27/25*
Time: 11:30:00
Report: 1043251027

Food and Beverage Establishment Inspection Report

Location:
Paradise Care Homes Llc
7709 Unity Avenue North
Brooklyn Park, MN55443
Hennepin County, 27

Establishment Info:
ID #: 0037450
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6128596065
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

4-300 Equipment Numbers and Capacities
4-302.12B ***** 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.
FACILITY HAS A DIAL THERMOMETER WITH A THICK PROBE. ADVISED STAFF TO PROVIDE A THIN PROBE THERMOMETER FOR TAKING INTERNAL TEMPERATURES OF THIN FOODS. COMPLY WITH ABOVE RULE.
Comply By: 01/27/25

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 TEST KIT AVAILABLE DURING INSPECTION. ADVISED STAFF TO REPURCHASE THERMOLABELS TO MEASURE UTENSIL SURFACE TEMPERATURE OF DISH MACHINE. COMPLY WITH ABOVE RULE.
Comply By: 01/27/25

4-300 Equipment Numbers and Capacities
4-302.14 ***** Priority 2 *****
MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.
FACILITY HAS A CONTAINER OF SANITIZER (QUATERNARY AMMONIA). ADVISED STAFF TO PROVIDE APPROPRIATE TEST KIT. MAINTAIN SANITIZER SOLUTION BETWEEN 200-400 PPM. COMPLY WITH ABOVE RULE.
Comply By: 01/27/25

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.

REPEAT FROM 7/11/22. WET CLOTH STORED BESIDE SINK. ADVISED STAFF TO (1) STORE WET CLOTH IN A SANITIZER BUCKET IN BETWEEN USES OR (2) REMOVE WET CLOTH IMMEDIATELY AFTER EACH USE AND PROVIDE CLEAN, DRY CLOTH FOR NEXT USE. COMPLY WITH ABOVE RULE.

Comply By: 01/27/25

6-300 Physical Facility Numbers and Capacities

6-301.14A

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

NO REMINDER POSTED AT KITCHEN HANDWASHING SINK. ADVISED STAFF TO POST. SIGN PROVIDED WITH REPORT. COMPLY WITH ABOVE RULE.

Comply By: 01/27/25

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.

REPEAT FROM 7/11/22. WALL BEHIND SINK AREA DAMAGED WITH EXPOSED DRY WALL. EDGES OF CABINETRY IS CHIPPING WITH EXPOSED WOOD MATERIAL. ADVISED STAFF TO REPAIR AND MAINTAIN. COMPLY WITH ABOVE RULE.

Comply By: 01/27/25

Surface and Equipment Sanitizers

Hot Water: = at 170 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: BUTTER
Temperature: 41 Degrees Fahrenheit - Location: FRIDGE
Violation Issued: No

Process/Item: CHEESE
Temperature: 41 Degrees Fahrenheit - Location: FRIDGE
Violation Issued: No

Process/Item: MILK
Temperature: 41 Degrees Fahrenheit - Location: FRIDGE
Violation Issued: No

Type: Full
Date: *01/27/25*
Time: 11:30:00
Report: 1043251027
Paradise Care Homes Llc

Food and Beverage Establishment Inspection Report

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

Inspection was completed with B. Nyangena as the lead Health Regulation Division Nurse Evaluator completing the site survey.

Discussed highly susceptible populations, date marking, illness policy, sanitizer use, ware washing, temperature control, cleaning, pest control, vomit/fecal procedures, test kits, food storage, and food handling procedures.

This facility has a residential kitchen with residential equipment, laminate flooring, painted walls, textured ceiling, and wood/composite cabinetry. Some wear and tear observed on wall behind sink area and cabinetry.

Utensil surface temperature of dish machine must reach at least 160F degrees (or 150F degrees for NSF/ANSI 184 residential dish machine). Dish machine has a sanitizing option - sanitizing option must always be used when running a cycle.

*Contact Health Regulation Division for plan review approval when facility/kitchen undergoes remodeling.

***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.

If any customer complains of illness, establishment is required to notify the Minnesota Department of Health and provide the foodborne illness hotline phone number to the customer: 1-877-366-3455

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 1043251027 of 01/27/25.

Certified Food Protection Manager: Ngoc Ba Phung

Certification Number: FM97317 Expires: 02/04/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Edna Adan Farah
Assisted Living Director

Signed: Blia Lor
Blia Lor
Public Health Sanitarian I
651-355-0641
blia.lor@state.mn.us