Electronically Delivered

March 25, 2025

Licensee
Hawthorne House Inc.
6909 Country Club Drive
Golden Valley, MN 55427

RE: Project Number(s) SL23667015

Dear Licensee:

On February 24, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine the correciton of orders from the survey completed on August 23, 2024, and the follow-up survey completed on November 4, 2024. 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,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

JMD

Electronically Delivered

February 10, 2025

Licensee
Hawthorne House Inc.
6909 Country Club Drive
Golden Valley, MN 55427

RE: Project Number(s) SL23667015

Dear Licensee:

On November 4, 2024, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on August 23, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the August 23, 2024 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on August 23, 2024, found not corrected at the time of the November 4, 2024, follow-up survey and/or subject to penalty assessment are as follows:

0820 - Fire Protection And Physical Environment - 144g.45 Subd. 2 (g)

The details of the violations noted at the time of this follow-up survey completed on November 4, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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**.

Also, at the time of this follow-up survey completed on November 4, 2024, we identified the following violation(s):

0340 - Correction Orders - 144g.30 Subd. 5

The details of the violation(s) noted at the time of this follow-up survey are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these state correction orders. It is not necessary to develop a plan of correction.

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 outlined on the state form; however, plans of correction are not required to be submitted for approval.

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

We urge you to review these orders carefully. If you have questions, please contact Jess Schoenecker at 651-201-3789.

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

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23667	A. BUILDING: _____ B. WING _____	R 11/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAWTHORNE HOUSE INC	6909 COUNTRY CLUB DRIVE 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 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: SL#23667015-1 On November 4, 2024, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on August 23, 2024. At the time of the survey, there were 4 active residents; 4 receiving services under the Assisted Living license. As a result of the revisit, the following orders were reissued and/or issued.	{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 License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 340 SS=I	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever	0 340		

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0 340	Continued From page 1 the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or staff of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must: (1) document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to take corrective actions related to a citation originally issued on August 23, 2024, for failing to provide resident bedrooms with the minimum window opening meeting the minimum state standard for egress. This had the potential to directly affect all residents, staff, and visitors. 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	0 340		

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0 340	Continued From page 2 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). On November 4, 2024, surveyor conducted a revisit to follow-up on orders issued pursuant to a follow up survey completed on August 23, 2024. During phone interview on November 4, 2024, at 10:45 a.m. licensed assisted living director (LALD)-A stated the windows in bedrooms #1 and #2 have not been replaced, were on back order, and hopefully will be installed November 15, 2024. On November 4, 2024, at 11:05 p.m. surveyor toured the facility with unlicensed personnel (ULP)-F. During the tour, surveyor asked to open the windows in the resident bedrooms #1 and #2 for measurement. The noncompliant measurement was as follows: Occupied Resident Sleeping Room: Bedroom #1: window measured 31 inches clear width, 17 inches clear height, and 527 square inches total open area. Bedroom #2: window measured 31 inches clear width, 17 inches clear height, and 527 square inches total open area. The windows in bedrooms #1 and #2 did not meet the minimum requirements for clear height and total openable area. On November 4, 2024, at 11:20 a.m. ULP-F stated there is no active Firewatch being performed by licensee.	0 340		

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0 340	Continued From page 3 During phone interview on November 5, 2024, at 1:42 p.m. LALD-A stated there is a Firewatch being performed by the licensee during the night shift (11:00 p.m. to 7:00 a.m.) only, and not performed during the day shift (7:00 a.m. to 3:00 p.m.) or evening shift (3:00 p.m. to 11:00 p.m.). LALD-A also stated licensee thought Firewatch only needed to be performed overnight and not continuous. No additional information was provided.	0 340		
{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	{0 480}		

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{0 480}	Continued From page 4 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 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:	{0 480}	Not reviewed during this survey.	
{0 660} SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current	{0 660}		

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{0 660}	Continued From page 5 tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by:	{0 660}	Not reviewed during this survey.	
{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	{0 680}		

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{0 680}	Continued From page 6 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}		
{0 790} SS=F	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by:	{0 790}	Not reviewed during this survey.	
{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;	{0 810}	Not reviewed during this survey.	

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{0 810}	Continued From page 7 (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:	{0 810}	Not reviewed during this survey.	
{0 820} SS=I	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be	{0 820}		

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{0 820}	Continued From page 8 permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedrooms with the minimum window opening meeting the minimum state standard for egress. This had the potential to affect all residents, staff, and visitors. 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: On November 4, 2024, surveyor conducted a revisit to follow-up on orders issued pursuant to a follow up survey completed on August 23, 2024. During phone interview on November 4, 2024, at 10:45 a.m. licensed assisted living director (LALD)-A stated the windows in bedrooms #1 and	{0 820}		

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{0 820}	Continued From page 9 #2 have not been replaced, were on back order, and hopefully will be installed November 15, 2024. On November 4, 2024, at 11:05 p.m. surveyor toured the facility with unlicensed personnel (ULP)-F. During the tour, surveyor asked to open the windows in the resident bedrooms #1 and #2 for measurement. The noncompliant measurement was as follows: Occupied Resident Sleeping Room: Bedroom #1: window measured 31 inches clear width, 17 inches clear height, and 527 square inches total open area. Bedroom #2: window measured 31 inches clear width, 17 inches clear height, and 527 square inches total open area. The windows in bedrooms #1 and #2 did not meet the minimum requirements for clear height and total openable area. Surveyor explained to ULP-F that at least one window in each bedroom in a state-licensed facility must meet the minimum state fire code standard for an egress window to be a complying bedroom for resident occupancy. ULP-F verbally confirmed the findings. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. On November 4, 2024, at 11:20 a.m. ULP-F stated there is no active Firewatch being performed by licensee.	{0 820}		

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{0 820}	Continued From page 10 During phone interview on November 5, 2024, at 1:42 p.m. LALD-A stated there is a Firewatch being performed by the licensee during the night shift (11:00 p.m. to 7:00 a.m.) only and not performed during the day shift (7:00 a.m. to 3:00 p.m.) or evening shift (3:00 p.m. to 11:00 p.m.). LALD-A also stated licensee thought Firewatch only needed to be performed overnight and not continuous. No further information was provided.	{0 820}		
{01290} SS=D	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of 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:	{01290}	Not reviewed during this survey.	
{01620} SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring	{01620}		

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{01620}	Continued From page 11 (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by:	{01620}	Not reviewed during this survey.	
{02320} SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract	{02320}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23667	A. BUILDING: _____ B. WING _____	R 11/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAWTHORNE HOUSE INC	6909 COUNTRY CLUB DRIVE 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
{02320}	Continued From page 12 and the service plan. This MN Requirement is not met as evidenced by:	{02320}	Not reviewed during this survey.	

Electronically Delivered

September 27, 2024

Licensee
Hawthorne House Inc.
6909 Country Club Drive
Golden Valley, MN 55427

RE: Project Number(s) SL23667015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 23, 2024, 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.

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,

Kelly Thorson

Kelly Thorson, Supervisor
State Evaluation Team
Email: kelly.thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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: SL23667015 On August 19,2024, through, August 23, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 3 resident(s); 3 receiving services under the provider's Assisted Living Facility license. An immediate correction order was identified on August 20, 2024, issued for SL23667015-0, tag identification 0820. On August 22, 2024, the immediacy of correction order 0820 was removed, however non-compliance remained at and scope and level of H.	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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0 480	Continued From page 1	0 480		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated August 19, 2024, 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		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control	0 660		

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0 660	Continued From page 2 (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) and Minnesota Department of Health (MDH), including a history and symptoms screening for active TB along with completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for one of one employees (registered nurse (RN)-E). This practice resulted in a level two 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 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).	0 660		

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0 660	Continued From page 3 The findings include: The facility's TB risk assessment was completed on February 14, 2024, and the facility was determined to be a low risk level. RN-E was hired on March 29, 2024, to provide direct care services to residents and supervision of staff. RN-E's employee record contained a negative quantiferon (R)- TB gold plus test dated March 27, 2024. The employee record lacked evidence of a history and symptoms screening for active TB. On August 22, 2024, at 8:15 a.m., licensed assisted living director / owner (LALD/O)-A stated the licensee was unable to locate RN-E's history and symptom screening document.. LALD/O-A stated that all employees are required to complete the history and symptoms screen at time of hire, however, RN-E's employee file lacked the documentation. The licensee's undated Conducting Appropriate Screenings, or Documentation of Prior Screenings, to Show that Staff are Free of Tuberculosis, Consistent with Current United States Centers for Disease Control and Preventions Standards policy indicated screening all staff providing services, both paid and unpaid, at the time of hire for active TB disease and latent TB infection would be documented in the services' [sic] file. The license's Tuberculosis Screening / Prevention policy dated August 1, 2024, indicated [the facility] will observe the recommended precautions related to TB prevention as identified	0 660		

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0 660	Continued From page 4 by the Centers of Disease Control and Prevention (CDC) and the Minnesota Department of Health (MDH). The precautions include a risk assessment, TB Screening, and staff education. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
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.	0 680		

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0 680	Continued From page 5 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all visitors, employees, and residents. 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 the residents). The findings include: The licensee's EPP dated December 18, 2023, lacked documentation including all the required elements of: -procedures for tracking of staff and patients; - policies and procedures for volunteers; and - roles under a waiver declared by secretary. On August 20, 2024, at 11:07 a.m., licensed assisted living director/owner (LALD/O)-A stated they had oversight of the emergency plan and stated the required contents was missing from the EPP and would correct to meet requirments. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated the licensee would implement the emergency management program as soon as the agency becomes aware. Licensee had identified a place to assure the safety and well-being of the resident and staff during periods of an emergency or disaster.	0 680		

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0 680	Continued From page 6 No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to perform the required annual and monthly maintenance on fire extinguishers as required. This had the potential to affect all current 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	0 790		

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0 790	Continued From page 7 a large portion or all of the residents). The findings include: On August 20, 2024, at 10:30 a.m., survey staff toured the facility with the licensed assisted living director/owner (LALD/O)-A. It was also observed the fire extinguishers on both levels did not have a service tag showing it had been inspected annually and lacked records to show the required monthly visual inspections were performed on the portable fire extinguishers. On August 20, 2024, at 11:00 a.m., LALD/O-A verified the required annual and monthly maintenance had not been completed. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation	0 810		

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0 810	Continued From page 8 plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide required employee training on fire safety and evacuation and failed to conduct required evacuation drills as required. This had the potential to affect all staff, residents, 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 August 20, 2024, at 12:00 p.m., licensed assisted living director/owner (LALD/O)-A	0 810		

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0 810	Continued From page 9 provided documentation on the fire safety and evacuation plan (FSEP), fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. TRAINING Record review of the available documentation indicated employees did not receive the fire safety and evacuation training twice yearly after initial hire. During the interview on August 20, 2024, at 12:30 p.m., LALD/O-A confirmed the facility provided only one fire safety training in new hire orientation to employees. LALD/O-A confirmed that there was no further documented training for the staff on the fire safety and evacuation plan as required by statute. DRILLS Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month as required by statute. Provided documentation indicated that the drills were conducted on 4/6/23, 4/8/23, 2/5/23, and 1/23/23, with no further drills being documented in the last two years. During the interview on August 20, 2024, at 12:30 p.m., LALD/O-A stated the facility provided only one drill and did not provide two drills per shift. LALD/CNS-A verified there were no further documented drills for the facility. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		

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0 820	Continued From page 10	0 820		
0 820 SS=H	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide a resident bedroom with the minimum window opening meeting the minimum state standard for egress. This affected the occupied resident in bedroom 1 and 2 on the main level. 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 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).	0 820	This immediate correction order identified on August 20, 2024, has had the immediacy lifted as of August 22, 2024, however non-compliance remained a scope and level of H.	

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0 820	Continued From page 11 The findings include: On August 20, 2024, at 10:30 a.m., survey staff toured the facility with the licensed assisted living director/owner (LALD/O)-A. During the facility tour, survey staff observed the following items: It was observed that occupied resident bedrooms 1 and 2 on the main level did not have windows that met the minimum size requirements for egress escape. The clear openable area of the opened windows measured 17 inches in height and 31 inches in width, with a total openable area of 527 square inches. The windows did not meet the minimum requirements for opening height and did not meet the minimum requirements for total openable area. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. Survey staff explained to LALD/O-A that at least one egress window in each bedroom must be provided to meet the minimum state standard for an egress window to be a complying bedroom for resident occupancy. LALD/O-A verbally confirmed the findings. On August 20, 2024, at 11:0 a.m., during the interview, survey staff explained to LALD/O-A that an immediate correction order was issued for the above finding. LALD/O-A acknowledged the above finding. No Further information was provided. TIME PERIOD FOR CORRECTION: Immediate.	0 820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23667	A. BUILDING: _____ B. WING _____	08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01290	Continued From page 12	01290		
01290 SS=D	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study (BGS) was submitted and received in affiliation with the assisted living license for one of one employee (registered nurse (RN)-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, 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 finding include:	01290		

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01290	Continued From page 13 On August 20, 2024, at 7:42 a.m., the surveyor compared the facility's employee list to the licensee's Minnesota Department of Human Services (DHS) NETStudy 2.0 roster and identified one employee who was not on the roster for health facility identification numbers (HFID) 23667. RN-E was hired March 29, 2024, to provide direct care services to residents and supervision of staff at the assisted living facility. RN-E ' s employee record contained a BGS dated March 29, 2024, affiliated with a sister facility. RN-E's employee record lacked evidence of current, cleared background study affiliated with the licensee's current assisted living HFID 23667. On August 20, 2024, at 7:42 a.m., licensed assisted living director / owner (LALD/O)-A stated they have long-term employees that were hired under a different HFID and was unsure if all employees were listed under the correct HFID. LALD/O-A stated she was unaware that all employees needed to be affiliated with all HFID ' s of the sister facilities they are employed at. No further information provided. TIME PERIOD OF CORRECTION: Two (2) days	01290		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the	01620		

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	23667	A. BUILDING: _____ B. WING _____	08/23/2024

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01620	Continued From page 14 resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the clinical nurse supervisor (CNS)-B and registered nurse (RN)-E completed a comprehensive nursing reassessment to include all required content identified per Minnesota (MN) Administrative Rule 4659.0150 Uniform Assessment Tool 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).	01620		

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01620	Continued From page 15 The findings include: R1 was admitted on April 28, 2006. R1's Nurse Reassessment Visits dated on February 14, 2024, May 10, 2024, and July 25, 2024, were a two (2) page document identified by RN-E as R1's 90-day reassessments. The documents were signed as completed by CNS-B. R1 reassessments lacked content identified by MN Administrative Rule 4659.0150 Uniform Assessment Tool in Subpart 2, Section A through Section O to be completed with each assessment and reassessment. On August 20, 2024, at 8:21 a.m., RN-B stated licensee used a 2-page assessment form for all assessments. She was not aware the assessment form did not contain all the required content. The licensee's Comprehensive Nursing Assessment policy dated August 1, 2021, stated the registered nurse will conduct a comprehensive assessment utilizing a uniform assessment tool. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7)	01620		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained	02320		

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02320	Continued From page 16 and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure unlicensed personnel (ULP) followed appropriate medication administration procedures for one of one employees (ULP)-D), observed during medication administration for 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 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-D was hired on May 11, 2024, to provide direct care services to residents. On August 20, 2024, at 7:15 a.m., the evaluator observed ULP-D provide medication administration to R1. ULP-D removed morning medications from medication set-up and placed them in a medication cup. ULP-D failed to verify scheduled medications to the medication administration record. On August 20, 2024, at 8:30 a.m., ULP-D stated she did not verify scheduled medications to the medication administration record (MAR) for R1	02320		

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02320	Continued From page 17 because she knows what medications resident receives. ULP-D stated she received training that include ULP's verify each medication to the medication record prior to administering any medication. On August 20, 2024, at 8:42 a.m., registered nurse (RN)-E stated ULP's receive medication training during orientation. ULP's are trained to verify medications to the MAR before administering to the resident. RN-E stated ULP's are expected to verify medications at every medication pass. The licensee's Staff Orientation and Education policy dated August 1, 2021, stated the registered nurse may delegate medication administration to an unlicensed staff member (home health aide) according to the following protocol: all home health aides have passed a competency evaluation with respect to all medication routes to be administered; the registered nurse has prepared written instructions for the home health aide in the proper methods to administer medications with respect to each resident; and the registered nurse has communicated with / provided orientation to the home health aide regarding the individual needs of the resident. All staff with responsibility for medication administration have access to information about the medication being administered, including but not limited to the purpose, dosage, route and frequency. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

DEPARTMENT OF HEALTH

Environmental Health
Food, Pools, and Lodging
625 Robert St. N
St. Paul
651-201-5000

Type: Full
Date: *08/19/24*
Time: 12:30:00
Report: 1031241208

Food and Beverage Establishment Inspection Report

Location:
Hawthorne House Assisted Livin
6909 Country Club Drive
Golden Valley, MN55427
Hennepin County, 27

Establishment Info:
ID #: 0038081
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6123859200
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.

ESTABLISHMENT DOES NOT HAVE A THIN PROBE THERMOMETER.

Comply By: 08/23/24

4-300 Equipment Numbers and Capacities

4-302.13B ***** Priority 2 *****

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

ESTABLISHMENT MISSING IRREVERSIBLE MEASURING DEVICE. PROVIDE IRREVERSIBLE MEASURING AND MEASURE UTENSIL TEMPERATURE (160F REQUIRED) AT REGULAR INTERVALS.

Comply By: 08/23/24

4-300 Equipment Numbers and Capacities

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

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

ESTABLISHMENT DOES NOT HAVE SANITIZER TESTING KIT ON SITE. PURCHASE KIT AND TEST SANI CONCENTRATION (50-200PPM BLEACH, 150-400PPM QUAT)

Comply By: 08/23/24

Surface and Equipment Sanitizers

Chlorine: = 100 at Degrees Fahrenheit
Location: Sani Bucket
Violation Issued: No

Hot Water: = at Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/Milk
Temperature: 39 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: No

Process/Item: Cold Hold/Apple Sauce
Temperature: 38 Degrees Fahrenheit - Location: DOwnstairs Refrigerator
Violation Issued: No

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

Nurse Evaluator on site: Lisa Schwintek

All violations discussed with Susanthi during the inspection.

COMMENTS:

Place garbage can in location where staff does not need to open cupboards to discard items. Taking doors off of cupboards is acceptable.

Run all dishes through dish machine. Use wash/rinse/sanitizer system only if dish machine is not meeting the 160F temp requirement.

NOTES:

- Establishment has a residential kitchen (4626.0506(G)(2)) Same-day service only. No saving and reheating of foods or preparation of foods the day prior to eating. Any remaining food from meals to be removed/discarded at end of day.

- Staff must prepare sanitizer bucket or squirt bottle daily. Check concentration with test strips (50-200ppm Chlorine) when preparing solution.

- Establishment does not have pasteurized eggs and does not prepare eggs for consumption under 145F. Purchase pasteurized eggs if intending to serve eggs undercooked.

- Make sure to datemark and cover (tupperware/ziplock/similar) any prepared cold items that are kept in refrigerator.

- Employee food needs to be labeled and separated from residents food.

- Cutting boards should be utilized as food contact surfaces and not counters or plates.

- - Establishment needs to check dish washer utensil temperature weekly (160F required). If utensil temp not reaching 160F, use washer to wash/rinse and sink basin with sanitizer solution to sanitize dishes then air dry, as discussed during inspection.

- 2-Comp sink has right basin designated for handwashing and the right basin for product washing/prep sink.

- When preparing food, make sure to use a thin-probe thermometer to check temperatures.

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Environmental Health inspection report number 1031241208 of 08/19/24.

Certified Food Protection Manager: Anna R. Kvelland

Certification Number: FM71061 Expires: 12/20/25

Inspection report reviewed with person in charge and emailed.

Signed: _____

Susanthi Fernando
Person in Charge

Signed: _____

Chris Foster
Public Health Sanitarian II
Freeman Office Building
651-983-8760
chris.j.foster@state.mn.us