Electronically Delivered

March 4, 2025

Licensee
Inver Grove Heights WP II LLC
9058 Buchanan Trail
Inver Grove Heights, MN 55077

RE: Project Number(s) SL27378016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 29, 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,

Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 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
	27378	A. BUILDING: _____ B. WING _____	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INVER GROVE HEIGHTS WP II LLC	9058 BUCHANAN TRAIL INVER GROVE HEIGHTS, MN 55077

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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: SL27378016 On January 27, 2025, through January 29, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 44 residents; 42 receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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.	
0 340 SS=F	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 interview and record review, the licensee failed to have sufficient documentation with actions taken to comply with correction orders (tag identification: 0480, 0680, 0800, 0810, and 2040 for a survey completed on January 20, 2022. This had the potential to affect all residents, staff, and visitors at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a	0 340		

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0 340	Continued From page 2 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 residents). The findings include: During the entrance conference on January 27, 2025, at 9:20 a.m., housing manager (HM)-A stated the licensee was familiar with current minimum assisted living requirements. The licensee provided an undated, Plan of Correction, which consisted of a summary page of tags and the corrective action taken and a power point of the corrective action taken for the nursing tags from the survey dated January 20, 2022. The corrective action taken was left blank for the following tags. 0480 144G.41 Subdivision 1. (13) (i) (B) Minimum requirements. 0680 144G.42 Subd. 10. Disaster planning and emergency preparedness plan. 0800 144G.45 Subd. 2 (a) (4) Fire protection and physical environment. 0810 144G.45 Subd. 2 (b-f) Fire protection and physical environment. 2040 144G.81 Subdivision 1. Fire protection and physical environment. The licensee lacked documentation to indicate correction orders previously cited on January 20, 2022, were in full compliance with assisted living with dementia care statutes. On January 29, 2025, at 3:00 p.m., housing manager (HM)-A provided a copy of the corrective action from the survey completed January 20, 2022, stating she was not in this position at the time of the previous survey.	0 340		

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0 340	Continued From page 3 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	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 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;	0 480		

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0 480	Continued From page 4 (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: 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:	0 480		

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0 480	Continued From page 5 Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated January 28, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post information related to the grievance procedure, resident advocacy information, and information for reporting suspected maltreatment. This had the potential to affect all residents, staff, and visitors.	0 550		

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0 550	Continued From page 6 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 January 27, 2025, at 10:00 a.m. during the facility tour with housing manager (HM)-A, the surveyor did not observe the licensee's grievance procedure, resident advocacy information, or information for reporting suspected maltreatment posted in any area of the licensee's facility. HM-A stated they do not have them posted and was not aware they were required. The licensee lacked postings in a conspicuous location and a disclosure of resident advocacy to include: -a posting with all required content of the licensee's grievance procedure and the name and email contact information for the individuals who are responsible for handling grievances. -contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. The licensee's Complaint/Grievance Posting policy, dated April 1, 2024, indicated the licensee will post, in a conspicuous place, information about the complaint/grievance procedure. The posting will also have the contact information for the Office of Ombudsman for Long Term Care	0 550		

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0 550	Continued From page 7 and the Ombudsman for Mental Health and Developmental Disabilities. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to support protection and safety by not posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) and failed to post the 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 640		

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0 640	Continued From page 8 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 residents). The findings include: On January 27, 2025, at 10:00 a.m. during the facility tour with housing manager (HM)-A, HM-A stated they used to be posted and were taken down. HM-A further indicated not being aware the postings were required. The licensee's Complaint/Grievance Posting policy dated April 1, 2024, indicated the licensee will post, in a conspicuous place, information about the complaint/grievance procedure. The posting will also include information for reporting suspected maltreatment to the Minnesota Adult Abuse Center. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
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;	0 680		

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0 680	Continued From page 9 (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 undated, Emergency Preparedness plan lacked the following required	0 680		

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0 680	Continued From page 10 content: - Procedures for tracking of staff and residents' location of on-duty and sheltered residents. - Policies and Procedures for Medical documents - Arrangement with other facilities - Roles under a waiver declared by Secretary - Primary/alternate means of communication - Methods of sharing information - Emergency Prep testing requirements On January 29, 2025, at 11:30 a.m., housing manger (HM)-A stated the licensee's current EP plan did not include the above content. HM-A stated she was new in this position and not aware of all the requirements. The licensee's Emergency Preparedness Plan-Appendix Z Compliance policy dated April 1, 2024, indicated the licensee would be aligned with the Centers for Medicare and Medicaid Services (CMS). No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (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 the current State Fire Code in Minnesota Rules, chapter 7511. This had the	0 775		

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0 775	Continued From page 11 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, 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). Findings include: During facility tour on January 29, 2025, from 10:45 a.m. to 12:30 a.m., with director of maintenance (DM)-J, it was observed that installed smoke alarms were over 10 years old from manufactures date in the several resident rooms on both levels of the facility. Single- and multiple-station smoke alarms shall be replaced when: 1. They fail to respond to operability tests. 2. They exceed ten years from the date of manufacture. Smoke alarms shall be replaced with smoke alarms having the same type of power supply. Resident units only had smoke alarms instead of combo smoke and carbon monoxide alarms. Carbon monoxide alarms are required due to the facility fuel fired heating and cooling systems. Some rooms had combo alarms but not all. DM-J stated they had started changing out alarms after the last survey but didn't finish. Resident unit fire doors did not close and latch automatically. Fire doors on resident rooms had	0 775		

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0 775	Continued From page 12 closing arms disconnected or missing closing unit all together. Fire doors are required to close and latch to reduce the spread of fire and smoke. DM-J didn't know why the fire doors had missing hardware or why hardware wasn't connected to perform as intended. During a facility tour on January 29, 2025, at 11:30 a.m., DM-J, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) day.	0 775		
0 800 SS=F	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. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain 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. This deficient condition 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	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27378	A. BUILDING: _____ B. WING _____	01/29/2025

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0 800	Continued From page 13 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: During facility tour on January 29, 2025, from 10:45 a.m. to 12:30 a.m., with director of maintenance (DM)-J. The following was observed. Resident room 43 had a section of torn carpet which could lead to a tripping hazard. DM-J was able to cut some loose string while on survey, but more repairs are needed. Resident room 30 didn't have any chalk around the toilet between the bottom and floor. The toilet appeared to be secured and working, but all chalking had been removed. Chalk will help secure the toilet and prevent water from potentially getting under the toilet and damaging the floor. 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	0 810		

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0 810	Continued From page 14 rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training. 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	0 810		

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0 810	Continued From page 15 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: During facility tour on January 29, 2025, from 10:45 a.m. to 12:30 a.m., director of maintenance (DM)-J; surveyor observed the posted evacuation plans lacked identification of resident rooms. Exit plan diagrams must be correctly labeled to reduce confusion and potential obstructions for egress in a fire or similar emergency. A copy of the facility floor plan should also be in the emergency preparedness binder to aid first responders in search and rescue operations. On January 29, 2025, housing manager (HM)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety training and evacuation drills, for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "Fire Safety", failed to include the following: RESIDENT ACTIONS: The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. On January 29, 2025, at 11:30 a.m., HM-A stated they understood the areas of their policy that	0 810		

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0 810	Continued From page 16 were incomplete and would work on bringing them into compliance. TRAINING: The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. Staff does web-based training at the time of hire, HM-A stated they were using evacuation drills as training. No other training documentation was provided. The licensee failed to provide evacuation training to residents at least once per year. HM-A lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. On January 29, 2025, at 11:30 a.m., HM-A stated they understood the requirements for training residents and staff and would implement a training program that was compliant with statute requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum:	01060		

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01060	Continued From page 17 (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide a written notice with the required content for an emergency relocation for R3 who was hospitalized.	01060		

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01060	Continued From page 18 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: R3 was admitted on March 23, 2020, with a diagnosis including dementia. R3's progress notes dated July 7, 2024, at 4:50 p.m., noted R3 was taken to the emergency room for evaluation and was admitted to the hospital. R3's progress notes dated July 11, 2024, at 3:23 p.m. noted R3 had returned from the hospital, for an inpatient stay of four days. R3's record lacked evidence of a written notice provided to the resident, the residents' legal representative, and designated representative and notification to the ombudsman that contained, at a minimum: - the reason for the relocation. - the name and contact information for the location to which the resident had been relocated and any new service provider. - contact information for the Office of Ombudsman for Long-Term Care (OOLTC); - if known and applicable, the approximate date or range of dates within which the resident was expected to return to the facility, or a statement that a return date was not currently known; and a statement that, if the facility refused to provide housing or services after a relocation, the	01060		

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01060	Continued From page 19 resident had the right to appeal and the contact information for the agency to which the resident may submit an appeal. On January 28, 2025, at 12:35 p.m., housing manager (HM)-A and registered nurse (RN)-B stated they were unaware of the emergency relocation procedures and thought it was related to the emergency preparedness manual and evacuation. The licensee's Emergency Relocation policy dated April 1, 2024, indicated in the event of an emergency relocation the licensee will prove a written notice to the resident, and designated representative, and the office of Ombudsman. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
01500 SS=F	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 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	01500		

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01500	Continued From page 20 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: (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	01500		

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01500	Continued From page 21 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 annual training included all required topics for each 12 months of employment for one of two employees (unlicensed personnel (ULP)-G). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: ULP-G had a start date of September 7, 2016, with the licensee to work in housekeeping; however, ULP-G began working as a ULP (providing direct care services) for the licensee in 2017. ULP-G's employee record contained annual training on September 20, 2017, July 6, 2018, and January 6, 2020. ULP-G's record also contained a document labeled caregiver-annual training indicating that on January 5, 2025, ULP-G completed Emergency preparedness training and on January 7, 2025, ULP-G completed Vulnerable adult refresher training. The following training was completed on January 28, 2025, (after the start of the survey). - Assisted living Bill of rights - Emergency preparedness overview MN AL	01500		

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01500	Continued From page 22 - Emergency preparedness Human hazards - Infection control - Dementia training - Organizations policies and procedures. ULP-G's employee record failed to show evidence of annual training on person-centered care and complaints and grievances. On January 28, 2025, at 9:00 a.m. ULP-G was observed assisting R12 with toileting, dressing, and applying creme. On January 29, 2025, at 10:25 a.m. housing manager (HM)-A stated she was aware that ULP-G had not completed their annual training and went home and completed it online last night (after the survey started). The licensee's Annual Required Staff Training Policy dated April 1, 2024, indicated the following training elements must be included every 12 months to all staff who performs direct care services: 1. Training on reporting maltreatment 2. Review of the assisted living bill of rights. 3. Review of infection control techniques. 4. Effective approached to problem solve when working with challenging behaviors. 5. Review of the facilities polices, and procedures related to the provision of assisted living services 6. Principles of person-centered planning and service delivery. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		

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	27378	A. BUILDING: _____ B. WING _____	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01540	Continued From page 23	01540		
01540 SS=F	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of two direct care employees (unlicensed personal (ULP)-G) received the required annual dementia training for each 12 months of employment. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).	01540		

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01540	Continued From page 24 The findings include: ULP-G had a start date of September 7, 2016, with the licensee to work in housekeeping; however, ULP-G began providing direct cares as a ULP for the licensee in 2017. On January 28, 2025, at 9:00 a.m., ULP-G was observed assisting R12 with toileting and dressing. ULP-G's employee record lacked evidence of completing two hours of dementia training for each 12 months of employment prior to the start of the survey. On January 29, 2025, at 10:25 a.m., housing manager (HM)-A stated she was aware that ULP-G had not completed their annual training and went home and completed it online last night (after the survey started). The licensee's Additional Dementia Staff Training policy dated April 1, 2024, indicated all direct care staff assigned to provide care for residents with dementia will be trained to work with residents with Alzheimer's disease and other dementia's. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01540		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has:	01750		

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	27378	A. BUILDING: _____ B. WING _____	01/29/2025

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01750	Continued From page 25 (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure delegated procedures were followed by one of two staff (unlicensed personnel (ULP)-E) observed during medication administration. 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: R7's diagnoses included Parkinson's disease (a neuro degenerative disease). R7's Service Plan dated January 28, 2025, indicated R7 received services including medication administration. On January 27, 2025, at 12:30 p.m., the surveyor observed ULP-E crushing carbidopa-levodopa (medication for Parkinson's disease) and	01750		

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	27378	A. BUILDING: _____ B. WING _____	01/29/2025

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01750	Continued From page 26 administer it to R7. R7's medication administration record (MAR) dated from January 21-28, 2025, included carbidopa-levodopa 25 milligrams (mg)-100 mg. The January 2025, MAR did not instruct the medication needed to be crushed. R7's medical record did not include a physician order to crush medications. On January 28, 2025, at 1:50 p.m., registered nurse (RN)-B stated they train ULPs on when to crush medications. RN-B stated "typically we do not crush carbidopa unless the physician has specifically okayed the crushing of medications." RN-B stated R7 did not have an order to crush medications. The licensee's Medication Management-Administration and Setup dated April 1, 2024, indicated medications should be in compliance with the resident's medication plan and administered as prescribed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27378	A. BUILDING: _____ B. WING _____	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INVER GROVE HEIGHTS WP II LLC	9058 BUCHANAN TRAIL INVER GROVE HEIGHTS, MN 55077

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01910	Continued From page 27 disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medications as required for one of one resident (R1) upon discharge. 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: R1 was admitted November 11, 2024, with a diagnosis of memory loss and received assistance with activities of daily living (ADLs) and medication management.	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27378	A. BUILDING: _____ B. WING _____	01/29/2025

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01910	Continued From page 28 R1's record contained a discharge summary dated January 10, 2025, that provided a summary of services provided during the course of services included medication administration, blood sugar checks and insulin administration. R1's January 2025, Mediation Administration Summary indicated R1 received the following scheduled medications: - Senna (for constipation) 8.6 mg twice daily. - acetaminophen 500 mg (for pain control) - Jardiance 25 mg (for diabetes) - Basaglar (insulin) 100 units/ml - omeprazole (for heartburn) 20 mg daily. R1's record contained a medication release form identifying the medication name, dosage, and amount of medication sent with the family upon discharge. R1's medication release form did not include the prescription number as required. On January 27, 2025, at 2:50 p.m., registered nurse (RN)-B stated R1's discharge summary did not include the prescription numbers and she was not aware that needed to be included in the discharge summary. The licensee's Disposition or Disposal of Medications policy was requested but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment	02040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27378	A. BUILDING: _____ B. WING _____	01/29/2025

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02040	Continued From page 29 An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to conduct mitigation for hazard vulnerability or safety risk assessment on or around the facility property. 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 residents). The findings include: During record review on January 29, 2025, from 10:45 a.m. to 12:30 a.m., with director of maintenance (DM)-J and housing manager (HM)-A. The licensee failed to provide mitigation for the hazards on the hazard vulnerability assessment (HVA). Facility did have a HVA completed with percentages assigned to each vulnerability, the assessment was missing	02040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27378	A. BUILDING: _____ B. WING _____	01/29/2025

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02040	Continued From page 30 mitigation's to take when and if those hazards happened. On January 29, 2025, at 11:30 a.m. HM-A and DM-J stated they understood the requirements and would implement mitigation's for hazards identified on HVA. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02040		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure signage was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all residents, staff, and visitors of the licensee. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents).	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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03090	Continued From page 31 The findings include: On January 27, 2025, at 10:00 a.m. during the facility tour with housing manager (HM)-A, the surveyor did not observe the licensee's electronic monitoring sign. HM-A stated they used to be posted but must have been taken down. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090		

DEPARTMENT OF HEALTH

Type: Full
Date: *01/28/25*
Time: 14:13:45
Report: 1036251019

Food and Beverage Establishment Inspection Report

Location:
Inver Grove Heights White Pine
9058 Buchanan Trail
Inver Grove Heights, MN55075
Dakota County, 19

Establishment Info:
ID #: 0024685
Risk: High
Announced Inspection: No

License Categories:

Expires on: / /

Operator:
Inver Grove Heights WPII, LLC

Phone #: 6514556549
ID #: 31711

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.

2-100 Supervision

2-102.11JKLMO ***** Priority 2 *****

MN Rule 4626.0030JKLMO The person in charge must be able to demonstrate their knowledge to the inspector of the food safety risks within their food operation and the relationship of the following factors to preventing foodborne disease: maintaining the food establishment and equipment in a clean condition and in good repair; procedures for cleaning and sanitizing utensils and food-contact surfaces of equipment; the importance of adequate food service equipment; responsibilities when a HACCP plan is required; proper use of toxic compounds in the establishment; and preventing contamination of the water supply from plumbing cross connections or backflow.

OBSERVED SOME RESIDUE/FOOD DEBRIS UNDERNEATH THE OVENS. ADVISED TO CLEAN AT A GREATER FREQUENCY TO PREVENT SUCH ACCUMULATION.

Comply By: 02/18/25

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.

NO CHLORINE TEST STRIPS ON SITE FOR MEASURING THE SANITIZER CONCENTRATION. MDH SUPPLIED A FEW TEST STRIPS UNTIL MORE CAN BE OBTAINED.

Comply By: 02/18/25

3-300B Protection from Contamination: cross-contamination, eggs

3-302.12

MN Rule 4626.0240 Properly label all working containers holding food or food ingredients that are removed from orginal packages with the common name of the food. Label the food in English and any other languages used by employees who handle food.

OBSERVED CONTAINERS OF SUGAR AND FLOUR STORED UNDER THE PREP TABLE WITH NO CONTENT LABEL. ISSUE CORRECTED ON SITE.

Comply By: 01/28/25

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

OBSERVED A DAMAGED GASKET SEAL ON THE ARCTIC AIR SINGLE DOOR REACH IN FREEZER. REPLACE AND MAINTAIN.

Comply By: 02/18/25

4-600 Cleaning Equipment and Utensils

4-602.12

MN Rule 4626.0850 Clean the food contact surfaces of cooking and baking equipment and interior cavities of microwave ovens at least every 24 hours.

OBSERVED SOME FOOD SPLATTER IN THE MICROWAVE. CESAR EXPLAINED HE CLEANS IT WEEKLY. ADVISED TO CLEAN AT LEAST ONCE PER DAY AS REQUIRED BY ABOVE RULE.

Comply By: 02/18/25

4-900 Protecting Clean Items

4-904.11B

MN Rule 4626.0965B Present clean knives, forks, and spoons that are not prewrapped in trays and holders so that only the handles are touched by employees or consumers.

OBSERVED FORKS AND SPOONS STORED IN CONTAINERS WITH THE HANDLES FACING DOWNWARD. ADVISED TO FLIP UTENSILS OVER SO THEY ARE STORED APPROPRIATELY AS REQUIRED BY ABOVE RULE.

Comply By: 02/18/25

6-100 Physical Facility Construction Materials

6-101.11A1

MN Rule 4626.1325A1 Provide smooth, durable, and easily cleanable floor, wall and ceiling surfaces.

OBSERVED SOME CRACKING/DAMAGE ON THE KITCHEN CEILING BY THE 3 COMP SINK. REPAIR AND MAINTAIN.

Comply By: 02/18/25

6-200 Physical Facility Design and Construction

6-202.11A

MN Rule 4626.1375A Provide effective shielding, coated or shatter-resistant light bulbs for all light fixtures where there is exposed food, clean equipment, utensils and linens, or unwrapped single-service or single-use articles.

OBSERVED A CRACKED LIGHT SHIELD OVER THE PREP TABLE. REPLACE AND MAINTAIN.

Comply By: 02/18/25

Type: Full
Date: *01/28/25*
Time: 14:13:45
Report: 1036251019
Inver Grove Heights White Pine

Food and Beverage Establishment Inspection Report

Surface and Equipment Sanitizers

UTENSIL SURFACE TEMP: = at 161 Degrees Fahrenheit
Location: HIGH TEMP DISH MACHINE
Violation Issued: No

Chlorine: = 100 at Degrees Fahrenheit
Location: 3 COMP SINK SANITZER DISPENSER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Ambient Temp
Temperature: -3 Degrees Fahrenheit - Location: ARCTIC AIR SINGLE DOOR REACH IN FREEZER
Violation Issued: No

Process/Item: Ambient Temp
Temperature: 33 Degrees Fahrenheit - Location: MAXIMUM DOUBLE DOOR REACH IN COOLER
Violation Issued: No

Process/Item: Ambient Temp
Temperature: 0 Degrees Fahrenheit - Location: MAXIMUM DOUBLE DOOR REACH IN FREEZER
Violation Issued: No

Process/Item: Ambient Temp
Temperature: 35 Degrees Fahrenheit - Location: PEAK COLD REACH IN COOLER
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	2	6

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. SURVEYOR FROM HRD WAS TRACEY FEARON. INSPECTION CONDUCTED IN PRESENCE OF ANTHONY AVANT, THE PERSON IN CHARGE AND CESAR. KITCHEN TYPICALLY SERVES BREAKFAST, LUNCH, AND DINNER FOR APPROXIMATELY 43 RESIDENTS. FOOD SUPPLY IS PROVIDED BY UPPER LAKES FOODS.

TOPICS DISCUSSED WITH THE PERSON IN CHARGE:
- EMPLOYEE ILLNESS LOG AND EXCLUSION POLICY.
- HAND WASHING POLICY AND REVIEW.
- GLOVE USAGE.
- NO BHC WITH RTE FOODS.
- THERMOMETER USE AND CALIBRATION.
- DATE MARKING TCS FOODS.
- PEST CONTROL.
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS.
-ALL VIOLATIONS ON THIS REPORT

FOR COMPLY BY DATES, REFER TO FULL REPORT BY HRD.

**IF ANY RESIDENT COMPLAINS OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT

Food and Beverage Establishment Inspection Report

OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE CUSTOMER. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 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 inspection report number 1036251019 of 01/28/25.

Certified Food Protection Manager: ANTHONY P. AVANT

Certification Number: 94796 Expires: 08/25/27

Inspection report reviewed with person in charge and emailed.

Signed: _____

ANTHONY AVANT
PERSON IN CHARGE

Signed: _____

Jeff Johanson