Electronically Delivered

September 29, 2022

Administrator
Hometown Senior Living - Wedge
3610 Mount Vernon Court
Woodbury, MN 55129

RE: Project Number(s) SL28204015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on July 28, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health 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.

The enclosed State Form documents the state licensing orders. The Department of Health documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

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

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

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

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

The total amount you are assessed is $500.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction 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 issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

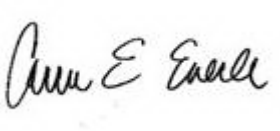
Free from Maltreatment reconsideration requests should be addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,



Carrie Euerle, Supervisor
Health Regulation Division
State Rapid Response Team
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, MN 55164-0970
Email: carrie.euerle@state.mn.us
Phone: 651-242-8846 Fax: 651-215-5963

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28204	A. BUILDING: _____ B. WING _____	07/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMETOWN SENIOR LIVING - WEDGE	3610 MOUNT VERNON COURT WOODBURY, MN 55129

(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 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 complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL28204015-0 On July 26, 2022 through July 28, 2022, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 28 residents receiving services under the provider's Assisted Living license.	0 000	Assisted Living Provider 144G. Minnesota Department of Health is documenting the State Licensing 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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0 120	Continued From page 1	0 120		
0 120 SS=C	144G.11 APPLICABILITY OF OTHER LAWS Assisted living facilities: (1) are subject to and must comply with chapter 504B; (2) must comply with section?325F.72; and (3) are not required to obtain a lodging license under chapter 157 and related rules. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure an assisted living facility advertising dementia care had an assisted living dementia care license in place. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The facility was licensed as an assisted living facility. During an interview on July 28, 2022, at 11:30 a.m., the executive director (ED)-A verified the licensee provided services to residents with a diagnosis of dementia. ED-A also stated they are aware of the assisted living facility dementia care license and had not attempted to obtain the license at this time. The licensee's website was reviewed and it	0 120		

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0 120	Continued From page 2 indicated the facility provided skilled services for dementia care as well as to provide an alternative choice to long term placement for seniors with high care and advanced dementia cares. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 120		
0 470 SS=C	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and	0 470		

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0 470	Continued From page 3 (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to post a staffing schedule daily in a central location, that was accessible to staff, residents, volunteers, and the public. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 26, 2022, during a tour at approximately 10:30 a.m. a Minnesota Department of Health (MDH) surveyor observed the staffing daily schedule posted on the right side of the upper floor medication room door in an area down a hall from the common area and kitchen. During an interview on July 27, 2022, at approximately 11:00 a.m., a copy of the facility's daily staffing plan was requested from the executive director (ED)-A who verified having a posted plan although it was redacted of staff names and not posted in a central location. The licensee lacked a daily staffing schedule developed by the clinical nurse supervisor to be posted after redacting direct-care staff member's resident assignments, at the beginning of each work shift in a central location in each building.	0 470		

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0 470	Continued From page 4 Licensee's policy 4.06 Staffing and Scheduling dated August 1, 2021, indicated the clinical nurse supervisor would develop and implement a written staffing plan and a daily staffing schedule. The daily work schedule must be posted, after redacting direct-care staff members' resident assignments, at the beginning of each work shift in a central location in each building of a facility or campus, accessible to staff, residents, volunteers, and the public. The facility shall not disclose any information that is protected by law from public disclosure. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 470		
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: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and	0 480		

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0 480	Continued From page 5 This MN Requirement is not met as evidenced by: Based on observation, and interview, 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 included document titled, Food and Beverage Establishment Inspection Report dated July 26, 2022, for the specific Minnesota Food Code deficiencies.	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision.	0 510		

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0 510	Continued From page 6 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to establish and maintain infection control policies and procedures that complied with accepted health care, medical, and nursing standards for infection control related to the COVID-19 pandemic when the licensee failed to ensure visitors, employees, and residents were screened for COVID-19 with temperature checks and screening questions at the entrance to the establishment and failed to develop policies and procedures to guide decision making related to COVID-19 pandemic. 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 all four residents). The findings include: COVID On July 26, 2022, at approximately 10:00 a.m., the surveyor was greeted by executive director (ED)-A wearing a face mask covering the nose and mouth. The surveyor was not screened at the front entrance before entering licensee's establishment. ED-A escorted the surveyor through common area and dining area to a room where other staff members were working. The surveyor requested to be screened and was informed by ED-A the visitors are not being screened at this time. INFECTION CONTROL	0 510		

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0 510	Continued From page 7 On July 26, 2022, at approximately 11:00 a.m., the surveyor observed unlicensed personnel (ULP)-H was without eye protection and face mask as she walked through a common area. The Minnesota Department of Health's COVID-19 Guidance: Long-term Care Indoor Visitation for Nursing Facilities and Assisted Living Settings dated 6/17/22 indicated Key components of visitation, as identified in QSO-20-39-NH Revised ? Screening visitors: Visitors who have a positive viral test for COVID-19 or symptoms of COVID-19, or who currently meet standards for quarantine should not enter the facility until they meet standards to end quarantine, isolation, or do not have symptoms. Facilities should screen all who enter for criteria that would exclude someone from visiting. The licensee's 8.01 Infection Control policy, dated August 1, 2021, indicated 1. Hometown Senior Living will identify areas where infection control practices are necessary based on the exposure and risk of the facility. 2. Hometown Senior Living's infection control program will be consistent with current guidelines from CDC for prevention control in long-term care facilities, where applicable in assisted living facilities. The Minnesota Department of Health COVID-19 Personal Protective Equipment (PPE) Grid for Congregate Care Settings dated April 7, 2022, instructed health care workers (HCW) with face-to-face contact with COVID-19 negative residents to wear a medical grade well-fitting facemask and eye protection. In addition, it instructed HCW with no face-to-face contact with residents to wear a medical-grade well-fitting	0 510		

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0 510	Continued From page 8 facemask. The Minnesota Department of Health (MDH) guidance titled, "COVID-19 PPE and Source Control Grids - for congregate care settings, by community transmission level", dated July 25, 2022, July 26, 2022, and July 27, 2022 indicated during "substantial" or "high" levels of community transmission (based on the Centers for Disease Control and Prevention (CDC) online data tracking system), caregivers must wear a face mask (source control) and eye protection while working with residents without suspected or confirmed SARS-CoV-2 infection. The CDC COVID Data Tracker on July 26, 2022, indicated Washington County, MN (the county of the assisted living facility) was at a "high" level of community transmission, which indicated the use of a face mask and eye protection while working with residents. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) Days	0 510		
0 530 SS=C	144G.41 Subd. 5 Resident councils The facility must provide a resident council with space and privacy for meetings, where doing so is reasonably achievable. Staff, visitors, and other guests may attend a resident council meeting only at the council's invitation. The facility must designate a staff person who is approved by the resident council to be responsible for providing assistance and responding to written requests that result from meetings. The facility must consider the views of the resident council and	0 530		

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0 530	Continued From page 9 must respond promptly to the grievances and recommendations of the council, but a facility is not required to implement as recommended every request of the council. The facility shall, with the approval of the resident council, take reasonably achievable steps to make residents aware of upcoming meetings in a timely manner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to designate a staff person who is approved by the resident council to be responsible for providing assistance and responding to written requests that result from resident council meetings. This has the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During an interview on July 28, 2022, at 11:30 a.m., the executive director (ED)-A stated they had not attempted to establish a resident council at this time. The licensee's Resident and Family Councils policy, dated August 1, 2021, indicated the licensee will provide residents and families the opportunity, space and privacy for meetings, as reasonably achievable. The licensee will, with approval of the councils, take reasonably	0 530		

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0 530	Continued From page 10 achievable steps to make residents and/or family's aware of upcoming meetings in a timely manner. Also, the policy indicated the licensee must designate a staff person who is approved by the resident council to be responsible for providing assistance and responding to written requests that result from meetings. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 530		
0 540 SS=C	144G.41 Subd. 6 Family councils The facility must provide a family council with space and privacy for meetings, where doing so is reasonably achievable. The facility must designate a staff person who is approved by the family council to be responsible for providing assistance and responding to written requests that result from meetings. The facility must consider the views of the family council and must respond promptly to the grievances and recommendations of the council, but a facility is not required to implement as recommended every request of the council. The facility shall, with the approval of the family council, take reasonably achievable steps to make residents and family members aware of upcoming meetings in a timely manner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to designate a staff person who is approved by the family council to be responsible for providing assistance and responding to written requests that result from resident council meetings. This has the potential to affect all residents.	0 540		

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0 540	Continued From page 11 This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During an interview on July 28, 2022, at 11:30 a.m., the executive director (ED)-A stated they had not attempted to establish a family council at this time. The licensee's Resident and Family Councils policy, dated August 1, 2021, indicated the licensee will provide residents and families the opportunity, space and privacy for meetings, as reasonably achievable. The licensee will, with approval of the councils, take reasonably achievable steps to make residents and/or family's aware of upcoming meetings in a timely manner. Also, the policy indicated the licensee must designate a staff person who is approved by the resident council to be responsible for providing assistance and responding to written requests that result from meetings. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 540		
0 570 SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to	0 570		

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	28204	A. BUILDING: _____ B. WING _____	07/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 570	Continued From page 12 any person who requests it. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to display the original current license at the main entrance of the assisted living facility as required. This had the potential to affect all of the licensee's current residents, staff and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On July 26, 2022, during a tour at approximately 10:30 a.m. the surveyor observed the facility's common areas and noted the lack of the required posting of the provisional assisted living license near the entrance common area of the facility. During a tour of the licensee on July 26, 2022, at approximately 10:45 a.m., a Minnesota Department of Health (MDH) surveyor observed the assisted living license posted on the right side of the upper floor medication room door in an area down a hall from the common area and kitchen. On July 26, 2022, at approximately 14:00 p.m. executive director (ED)-A verified the required information was not posted in the common areas of the facility near the main entrance.	0 570		

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0 570	Continued From page 13 The facility failed to display the original current license at the main entrance of the assisted living facility. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 570		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in and maintain documentation on quality management activities appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 580		

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0 580	Continued From page 14 or has the potential to affect a large portion or all of the residents). Findings include: During an interview on July 27, 2022, at approximately 11:00 a.m., a copy of the facility's quality management plan was requested from the executive director (ED)-A who verified not having a documented quality management activity. The licensee's 2.31 Quality Management Project policy dated August 1, 2021, contained required content related to Minnesota statute 144G.42 subd. 2 which indicated the licensee will have at least one documented quality management project in place at all times, and retain records of such projects for at least two years. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) Days	0 580		
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;	0 680		

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0 680	Continued From page 15 (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop an emergency preparedness plan (EPP) with all the required components included in Appendix Z. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: During an interview on July 27, 2022, at 13:00 p.m., executive director (ED)-A acknowledged they did not have all the required components of Appendix Z. The licensee's Fire and Emergency Evacuation	0 680		

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0 680	Continued From page 16 Plan lacked the following required content: -develop and maintain EP -maintain and annual EP updates -EP patient population -subsistence needs for residents and staff -policies and procedures including evacuation -policies and procedures for sheltering -policies and procedures for medical documents -policy and procedures for volunteers -arrangement with other facilities -roles under a waiver declared by Secretary -development of communication plan -names and contact information -emergency officials contact information -primary/alternate means of communication -methods for sharing information -sharing information on occupancy/needs -family notifications -EP prep training and testing -EP prep training program -EP prep testing requirements The licensee's Disaster Planning and Emergency Preparedness policy, dated August 1, 2021, indicated the licensee will have in place an emergency preparedness plan that is in alignment with facility's requirement to comply with CMS Appendix Z. Also, the licensee's Emergency Preparedness Plan- Appendix Z Compliance policy, dated August 1, 2021, indicated it is the intent that Hometown Senior Living has in place an effective and compliant Emergency Preparedness Plan. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 700 SS=F	144G.43 Subdivision 1 Resident record	0 700		

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0 700	Continued From page 17 (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure resident records were protected against unauthorized disclosure when resident medical records were left displayed on a computer screen unattended. This had the potential to affect all residents residing in the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 28, 2022, at approximately 10:45 a.m., the investigator observed an unsecured desktop computer display screen which was left unattended in the designated medication room on the first floor of the facility. The investigator was able to observe a medication administration record (MAR) of a current resident on the display screen. The display screen contained information including resident name and medications, and it	0 700		

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0 700	Continued From page 18 was visible to other residents, staff, and visitors. During interview on July 28, 2022, at approximately 11:00 a.m., administrator (AD)-C confirmed the unsecured desktop computer display screen which was left unattended. The licensee's policy titled, Client Record-Security and Storage policy, dated August 1, 2021, indicated resident records and resident information will be stored and secured in an area where only authorized staff will have access. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 700		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in	0 780		

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0 780	Continued From page 19 the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain smoke alarms in the facility. 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, but was not likely to cause serious injury, impairment, or death), and 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: 1. On 07/27/2022 between 09:15 AM to 11:00 AM, survey staff observed that the smoke alarm located in bedroom number 7 in the south building was missing. 2. On 07/27/2022 between 09:15 AM to 11:00 AM, survey staff observed that the smoke alarms in the South building were dated 2011, so they are older than 10 years old. ED- A and AD- C verbally confirmed survey staff observations. No further information was provided.	0 780		

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0 780	Continued From page 20 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		
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 provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On 07/27/2022, between 09:15 AM and 11:00 AM, survey staff toured the facility with ED-A and AD-C. During the facility tour, survey staff observed the following: 1. There was an escutcheon plate missing	0 800		

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0 800	Continued From page 21 around one sprinkler head in the upper-level hallway in the Central building. 2. The toilet in the lower level of the Central building was clogged. 3. The outlet in the bathroom in the North building was missing a screw and partially hanging off the wall. ED-A and AD-C verbally confirmed survey staff observations during the facility tour. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) 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 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.	0 810		

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0 810	Continued From page 22 (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 and resident 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). On 07/27/2022, between 09:15 AM and 11:00 AM, the ED- A and AD- C provided documents for review. Documents were reviewed by survey staff on 07/27/2022, between 09:15 AM and 11:00 AM, 1. The licensee failed to provide the required	0 810		

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0 810	Continued From page 23 employee training frequency. 2. The licensee failed to provide the required fire drill frequency. The ED-A and AD-C verbally confirmed survey staff observations during the facility tour. No additional information was provided TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety,	01370		

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01370	Continued From page 24 and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure training and competency reviews to include all required content with records for three of three employees, unlicensed personnel (ULP-D, ULP-E, and ULP-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-D was hired on April 18, 2022. ULP-D began providing assisted living services to licensee's residents on April 25, 2022. ULP-D's employee file lacked documentation of training and competency evaluations for the	01370		

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01370	Continued From page 25 following topics: -documentation requirements for all services provided; -reports of changes in the resident's condition to the supervisor designated by the facility; -maintenance of a clean and safe environment; -standby assistance techniques and how to perform them; -medication, exercise, and treatment reminders; -basic nutrition, meal preparation, food safety, and assistance with eating; -preparation of modified diets as ordered by a licensed health professional; -communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; -awareness of confidentiality and privacy; -awareness of commonly used health technology equipment and assistive devices. ULP-E was hired on February 17, 2020, under the comprehensive home care license. ULP-E began providing assisted living services on August 1, 2021. ULP-E's employee file lacked documentation of training and competency evaluations for the following topics: -documentation requirements for all services provided; -reports of changes in the resident's condition to the supervisor designated by the facility; -maintenance of a clean and safe environment; -standby assistance techniques and how to perform them; -medication, exercise, and treatment reminders; -basic nutrition, meal preparation, food safety, and assistance with eating; -preparation of modified diets as ordered by a licensed health professional;	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28204	A. BUILDING: _____ B. WING _____	07/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMETOWN SENIOR LIVING - WEDGE	3610 MOUNT VERNON COURT WOODBURY, MN 55129

(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
01370	Continued From page 26 -communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; -awareness of confidentiality and privacy; -awareness of commonly used health technology equipment and assistive devices. ULP-F was hired on May 12, 2022 and began providing assisted living services on May 20, 2022. ULP-F's employee file lacked documentation of training and competency evaluations for the following topics: -documentation requirements for all services provided; -reports of changes in the resident's condition to the supervisor designated by the facility; -maintenance of a clean and safe environment; -standby assistance techniques and how to perform them; -medication, exercise, and treatment reminders; -basic nutrition, meal preparation, food safety, and assistance with eating; -preparation of modified diets as ordered by a licensed health professional; -communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; -awareness of confidentiality and privacy; -awareness of commonly used health technology equipment and assistive devices. During an interview on July 27, 2022, at approximately 11:00 a.m., individual employee records were requested from the executive director (ED)-A who verified training had been completed but was recorded possibly off site.	01370		

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01370	Continued From page 27 The licensee's Competency Training Evaluations policy dated August 1, 2021, indicated when a registered nurse or licensed health professional staff of Hometown Senior Living delegates tasks, prior to the delegation of services they must make certain the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each client and are able to demonstrate the ability to competently follow the procedures and perform the tasks. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01370		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of	01470		

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01470	Continued From page 28 complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure three of three employees, unlicensed personnel (ULP-D, ULP-E, and	01470		

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01470	Continued From page 29 ULP-F), received the required orientation content for 144G licensing requirements with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-D was hired on April 18, 2022. ULP-D began providing assisted living services to licensee's residents on April 25, 2022. ULP-D's employee training records lacked evidence of successful completion of assisted living orientation in accordance with 144G statutes in the following areas: -an overview of 144G statutes -an introduction and review of the facility's policies and procedures related to the provision of assisted living services -handling of emergencies and use of emergency services -compliance with and reporting of the maltreatment of vulnerable adults -the assisted living bill of rights -the principles of person-centered planning and service delivery -handling of resident complaints, reporting of complaints, and where to report complaints -consumer advocacy services of the office of the Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and	01470		

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01470	Continued From page 30 Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services -a review of the types of assisted living services the employee will be providing and the facility's category of licensure ULP-E was hired on February 17, 2020, under the comprehensive home care license. ULP-E began providing assisted living services on August 1, 2021. ULP-E's employee training records lacked evidence of successful completion of assisted living orientation in accordance with 144G statutes. -an overview of 144G statutes -an introduction and review of the facility's policies and procedures related to the provision of assisted living services -handling of emergencies and use of emergency services -compliance with and reporting of the maltreatment of vulnerable adults -the assisted living bill of rights -the principles of person-centered planning and service delivery -handling of resident complaints, reporting of complaints, and where to report complaints -consumer advocacy services of the office of the Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services -a review of the types of assisted living services the employee will be providing and the facility's	01470		

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01470	Continued From page 31 category of licensure ULP-F was hired on May 12, 2022 and began providing assisted living services on May 20, 2022. ULP-F's employee training records lacked evidence of successful completion of assisted living orientation in accordance with 144G statutes. -an overview of 144G statutes -an introduction and review of the facility's policies and procedures related to the provision of assisted living services -handling of emergencies and use of emergency services -compliance with and reporting of the maltreatment of vulnerable adults -the assisted living bill of rights -the principles of person-centered planning and service delivery -handling of resident complaints, reporting of complaints, and where to report complaints -consumer advocacy services of the office of the Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services -a review of the types of assisted living services the employee will be providing and the facility's category of licensure During an interview on July 27, 2022, at approximately 11:00 a.m., individual employee records were requested from the executive director (ED)-A who verified training had been completed but was recorded possibly off site.	01470		

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01470	Continued From page 32 The licensee's policy titled, Orientation to Staff and Supervisors & Content, dated August 1, 2021, indicated all staff providing and supervising direct services must complete an orientation to Assisted Living facility licensing requirements and regulations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01470		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the licensee failed to ensure security and accountability for the overall management, control, and disposition of medications. This had the potential to affect all five residents receiving assisted living services, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	01880		

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01880	Continued From page 33 The findings include: On July 28, 2022, at approximately 10:45 a.m., the investigator observed medications unsecured and unattended in a medication cart located in the designated medication room on the first floor of the facility. The investigator was able to open all but one drawer in the medication cart, the investigator was unable to open a double-locked drawer, assuming it was the drawer containing narcotic medications. During interview on July 28, 2022, at approximately 11:00 a.m., administrator (AD)-C confirmed all resident prescription medications were stored in a lockable medicine cart inside of a designated medication room which was left unlocked, and the cart was left unlocked. During the same observation the surveyor noted that narcotic medications were stored in a double-locked system inside of the cart and which was secured by the second lock. The licensee's policy titled, Medication Storage, dated August 1, 2021, indicated the medications will be kept securely locked and stored per manufacturer's directions, accessible only to authorized staff. The policy also indicated Schedule II Drugs will be stored under a double lock system and stored separately from other medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors	03090		

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03090	Continued From page 34 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 and interview, the licensee failed to ensure a required notice was posted at the main entry way of the licensee's facility to display statutory language to disclose electronic monitoring activity. This had the potential to affect all residents, staff, and visitors to the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 26, 2022, at approximately 10:00 a.m., the Minnesota Department of Health (MDH) surveyor entered the facility and observed a sticker on the outside door stating security camera's in place although there was no electronic monitoring notice posted at the entrance to the licensee's facility. During an exit conference and interview on July	03090		

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03090	Continued From page 35 28, 2022, at approximately 11:00 a.m., executive director (ED)-A acknowledged the licensee failed to post the required electronic monitoring notice but stated that security camera stickers were placed at all doors. The licensee's policy 2.15 Electronic Monitoring dated August 1, 2021, indicated that signs are installed at each facility entrance accessible to visitors that state: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons or activities." TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090		

Minnesota Department of Health
Division of Environmental Health, FPLS
PO Box 64975
Saint Paul, 55164-0975
651-201-4500

Type: Full
Date: *07/26/22*
Time: 13:41:56
Report: 1023221127

Food and Beverage Establishment Inspection Report

Location:
Hometown Senior Living - Wedge
3610 Mount Vernon Court
Woodbury, MN55129
Washington County, 82

Establishment Info:
ID #: 0038024
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6517147075
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.

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

3-302.11A(1) ** Priority 1 **

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

OBSERVED RAW ANIMAL FOODS SUCH AS SHELL EGGS AND BEEF PATTIES STORED OVER READY TO EAT FOODS IN MULTIPLE REFRIGERATORS.

Comply By: 07/26/22

4-300 Equipment Numbers and Capacities

4-302.12B ** Priority 2 **

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

NO THERMOMETER AVAILABLE TO TAKE FOOD TEMPERATURES. ACQUIRE AND USE SUCH A DEVICE TO ENSURE SAFE FOOD TEMPERATURES.

Comply By: 07/26/22

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.

ANSI 184 HIGH TEMP DISH WASHER IN USE BUT NO WAY TO VERIFY MINIMUM TEMPERATURE OF 150dF FOR SAFE SANITIZATION.

Comply By: 07/26/22

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 TEST STRIPS AVAILABLE ON SITE.

Comply By: 07/26/22

4-600 Cleaning Equipment and Utensils

4-601.11A ** Priority 2 **

MN Rule 4626.0840A Equipment food-contact surfaces and utensils must be clean to sight and touch.

OBSERVED SPILLED FOOD IN SOUTH HOUSE GARAGE REFRIGERATOR.

Comply By: 07/26/22

5-200A Plumbing: approved materials/design

5-203.11A ** Priority 2 **

MN Rule 4626.1070A Provide at least 1 handwashing sink, or the number of handwashing sinks necessary to allow for the convenient use by employees during food preparation, food dispensing, and warewashing; and in or adjacent to toilet rooms.

NO HAND WASHING SINK PRESENT IN THE CENTRAL HOUSE MAIN KITCHEN AREA. OPERATOR MUST DESIGNATE A SINK BASIN AS A HAND WASHING SINK TO BE USED FOR HAND WASHING ONLY.

Comply By: 07/26/22

6-300 Physical Facility Numbers and Capacities

6-301.11 ** Priority 2 **

MN Rule 4626.1440 Provide an adequate supply of hand soap at each handwashing sink or group of 2 adjacent handwashing sinks.

NO SOAP PRESENT AT HAND SINK IN CENTRAL HOUSE. OPERATOR FOUND AND PROVIDED SOAP.

Comply By: 07/26/22

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

NO CFPM EMPLOYED. HAVE AT LEAST ONE STAFF MEMBER TAKE 8 HOUR CLASS, PASS THE TEST, AND REGISTER WITH MDH.

Comply By: 07/26/22

4-100 Equipment Construction Materials

4-101.17

MN Rule 4626.0490 Discontinue using wood and wood wicker as a food contact surface.

WOODEN SPOONS IN FOOD PREP AREA.

Comply By: 07/26/22

4-200 Equipment Design and Construction

4-201.11GMN

MN Rule 4626.0506G Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

OBSERVED LEFTOVERS FOODS PREPARED THE PREVIOUS DAY BEING COLD HELD IN NORTH HOUSE REACH IN COOLER. DISCONTINUE SAVING AND SERVING LEFTOVERS.

Comply By: 07/26/22

6-300 Physical Facility Numbers and Capacities

6-301.14A

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

NO HAND WASHING REMINDER SIGN PRESENT AT NORTH HOUSE MAIN KITCHEN.

Comply By: 07/26/22

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.111ABD

MN Rule 4626.1565ABD Provide control of insects, rodents, and other pests by routinely inspecting incoming food and supply shipments; routinely inspecting the premises for evidence of pests; and eliminating harborage conditions.

OBSERVED ANTS IN KITCHEN AREA OF CENTRAL HOUSE. KEEP ALL FACILITIES FREE OF PESTS.

Comply By: 07/26/22

Surface and Equipment Sanitizers

Hot Water: = at >150 Degrees Fahrenheit
Location: ANSI 184 DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/MILK
Temperature: 40 Degrees Fahrenheit - Location: REACH IN COOLER UPSTAIRS SOUTH HOUSE
Violation Issued: No

Process/Item: Cold Hold/MILK
Temperature: 41 Degrees Fahrenheit - Location: REACH IN COOLER UPSTAIRS SOUTH HOUSE
Violation Issued: No

Process/Item: Cold Hold/JUICE
Temperature: 41 Degrees Fahrenheit - Location: REACH IN COOLER UPSTAIRS SOUTH HOUSE
Violation Issued: No

Process/Item: Cold Hold/MILK
Temperature: 43 Degrees Fahrenheit - Location: REACH IN COOLER UPSTAIRS CENTRAL HOUSE
Violation Issued: Yes

Process/Item: Cold Hold/BEEF
Temperature: 40 Degrees Fahrenheit - Location: REACH IN COOLER UPSTAIRS NORTH HOUSE
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	1	6	5

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. SURVEYOR FROM HRD WAS JAMES LARSON. INSPECTION CONDUCTED IN PRESENCE OF SAMI LOPEZ , THE PERSON IN CHARGE. ALL VIOLATIONS WERE DISCUSSED WITH PERSON IN CHARGE AND HRD EVALUATOR DURING INSPECTION.

FOOD SERVICE AREA FLOORS, WALLS, CEILINGS, COUNTERTOPS, AND FINISH MATERIALS MUST BE NON-ABSORBANT, SMOOTH, DURABLE, AND EASILY CLEANABLE. CEILINGS CANNOT HAVE POPCORN TEXTURE. CABINETS CANNOT HAVE HOLLOW BASES. EXPOSED WOOD IS NOT APPROVED FOR FOOD SERVICE AREAS. ANYWHERE FOOD IS STORED OR PREPARED IS A FOOD SERVICE AREA.

THIS FACILITY DOES NOT HAVE COMMERCIAL GRADE ANSI EQUIPMENT. ALL FOOD MUST BE SERVED THE SAME DAY IT IS PREPARED, AND LEFTOVERS CAN NEVER BE SAVED.

THESE ADDITIONAL TOPICS WERE DISCUSSED WITH THE PERSON IN CHARGE:
- EMPLOYEE ILLNESS EXCLUSION
- HAND WASHING PROCEDURE
- NO BARE HAND CONTACT WITH RTE FOOD
- VOMIT CLEAN UP PROCEDURE
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS
- ANSI 184 STANDARD FOR RESIDENTIAL DISH WASHER

DOCUMENTS ON THE FOLLOWING TOPICS WERE INCLUDED WITH INSPECTION REPORT:
- EMPLOYEE ILLNESS TRACKING
- SAMPLE VOMIT CLEAN UP PROCEDURE
- SAMPLE HANDWASHING SIGN
- HIGH RISK POPULATION REQUIREMENTS
- ANSI 184 STANDARD FOR RESIDENTIAL DISH WASHER

FOR CORRECT BY DATES REFER TO COMPLETE REPORT ISSUED BY HRD.

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1023221127 of 07/26/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____

SAMI LOPEZ
PERSON IN CHARGE

Signed: Gregory T Nelson

Gregory T. Nelson
Public Health Sanitarian
Freeman Building
651-201-4259
greg.nelson@state.mn.us