



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 9, 2025

Licensee
Guardian Care Homes Inc.
7221 First Avenue South
Richfield, MN 55423

RE: Project Number(s) SL38523016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 15, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 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.

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

0330 - 144g.30 Subd. 4 - Information Provided By Facility - \$500.00

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

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

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To submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in cursive script that reads "Renee L. Anderson".

Renee Anderson, Supervisor

State Evaluation Team

Email: Renee.L.Anderson@state.mn.us

Telephone: 651-201-5871 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38523	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/15/2025
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NAME OF PROVIDER OR SUPPLIER GUARDIAN CARE HOMES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7221 FIRST AVENUE SOUTH RICHFIELD, MN 55423
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0 000	<p>Initial Comments</p> <p>****ATTENTION****</p> <p>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.</p> <p>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.</p> <p>INITIAL COMMENTS:</p> <p>SL38523016-0</p> <p>On May 12, 2025, through May 15, 2025, the Minnesota Department of Health conducted a full survey at the above provider, and the following orders are issued. At the time of the survey, there were two residents, both receiving services under the Assisted Living Facility license.</p>	0 000	<p>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.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>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.</p>	
0 330 SS=F	<p>144G.30 Subd. 4 Information provided by facility</p> <p>(a) The assisted living facility shall provide</p>	0 330		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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0 330	<p>Continued From page 1</p> <p>accurate and truthful information to the department during a survey, investigation, or other licensing activities.</p> <p>(b) Upon request of a surveyor, assisted living facilities shall within a reasonable period of time provide a list of current and past residents and their legal representatives and designated representatives that includes addresses and telephone numbers and any other information requested about the services to residents.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide the Minnesota Department of Health (MDH) with accurate and truthful information during a survey, by falsifying the personnel record for one of two employees (unlicensed personnel (ULP)-D).</p> <p>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 the residents).</p> <p>The findings include:</p> <p>Clinical nurse supervisor (CNS)-C was hired May 1, 2025, to provide oversight and guidance to staff and provide direct care and services to residents of the facility.</p> <p>ULP-D was hired on May 5, 2025, to provide direct care and services to the residents of the facility.</p>	0 330		

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0 330	<p>Continued From page 2</p> <p>On May 13, 2025, at 8:35 a.m., the surveyor observed ULP-D assisting R1 with medication administration.</p> <p>CNS-C's employee record included documentation of a Quantiferon - TB Gold Plus (tuberculosis (TB) blood test) from "AM Physicians PA", printed July 22, 2024. The documentation indicated the test was collected June 18, 2024 at 16:01:00 (4:01 p.m.). The document further indicated the result of the blood test was received June 22, 2024, at 15:10:04 (3:10 p.m.).</p> <p>ULP-D's employee record included documentation of a Quantiferon - TB Gold Plus test from "AM Physicians PA". ULP-D's TB test documentation indicated it was collected at the same date and time as CNS-C's test: June 18, 2024 at 16:01:00 (4:01 p.m.). The documentation also indicated the result of the blood test was received at the same date and time as CNS-C's test: June 22, 2024, at 15:10:04 (3:10 p.m.).</p> <p>CNS-C and ULP-D's TB test documentation both included the same Accession Identification (a unique number assigned to a sample at the sampling laboratory), 17786117550, and the same "Lab Ref ID" (a unique number assigned to a sample at the test processing laboratory), 170L906751.</p> <p>CNS-C's TB test documentation included CNS-C's name and birthdate at the top and bottom of the form.</p> <p>ULP-D's TB test documentation included ULP-D's name and birthdate at the top of the form, but included CNS-C's name and birthdate at the</p>	0 330		

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0 330	<p>Continued From page 3</p> <p>bottom of the form, indicating ULP-D's test was a falsified document created by copying the same TB test documentation from CNS-C's record.</p> <p>On May 12, 2025, at approximately 11:30 a.m., during the entrance conference, CNS-C stated they would send an employee for TB testing if they did not have a test completed within 90 days before being hired.</p> <p>On May 15, 2025, at 8:15 a.m., licensed assisted living director (LALD)-A stated ULP-D was needed to provide direct care for residents immediately upon hire, therefore the licensee used an "old" Quantiferon test from a prior place of employment. LALD-A stated, in the future, the licensee needed to ensure all employees were screened and tested for TB prior to providing direct care to residents of the facility to make certain all residents were at the lowest possible risk for contracting TB.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Two (2) days</p>	0 330		
0 480 SS=F	<p>144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services</p> <p>(a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626.</p> <p>(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</p>	0 480		

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0 480	<p>Continued From page 4</p> <p>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;</p> <p>(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;</p> <p>(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;</p> <p>(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;</p> <p>(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;</p> <p>(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</p> <p>(7) notwithstanding Minnesota Rules, part</p>	0 480		

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0 480	<p>Continued From page 5</p> <p>4626.1390, toilet rooms are not required to be provided with a self-closing door.</p> <p>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.</p> <p>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).</p> <p>The findings include:</p> <p>Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated May 14, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.</p> <p>TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.</p>	0 480		
0 510 SS=F	<p>144G.41 Subd. 3 Infection control program</p> <p>(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.</p> <p>(b) The facility's infection control program must be</p>	0 510		

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0 510	<p>Continued From page 6</p> <p>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.</p> <p>(c) The facility must maintain written evidence of compliance with this subdivision.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to establish and maintain an effective infection control program that complied with accepted health care, medical, and nursing standards, and 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. This had the potential to affect all residents, staff, and visitors.</p> <p>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).</p> <p>The findings include:</p> <p>The licensee's records included an infection control policy, dated January 25, 2025, and a training program. Both documents addressed standard precautions for preventing transmission of infection. The licensee lacked an infection</p>	0 510		

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0 510	<p>Continued From page 7</p> <p>control program (ICP) to include the following:</p> <ul style="list-style-type: none"> - Person(s) assigned to oversee the ICP are qualified individuals with training in infection prevention and control to manage the licensee's infection prevention program; - Infection prevention policies and procedures were available, current, and based on evidence-based guidelines; - ICP identified how to provide appropriate infection prevention to residents, family members, visitors, and others; - ICP program manager was aware of resources available; - Infection prevention practices and infection control requirements were identified and monitored; - Prompt feedback provided on adherence and related outcomes to healthcare personnel and facility leadership; and - Surveillance plan was in place to monitor the incidences of infections that may be related to care at the facility and action was taken on the data and the information collected then used to detect transmission of infection agents in the facility. <p>On May 13, 2025, at 12:40 p.m., licensed assisted living director (LALD)-A, stated the ICP did not meet the expected standards. LALD-A stated, although the licensee understood they were dealing with high-risk and vulnerable residents and took it very seriously, the program was not developed or implemented to the specific needs of the residents or staff.</p> <p>The licensee's Infection Control Policy, dated January 25, 2025, indicated the licensee would observe the recommended precautions for home care as identified by the CDC. The precautions would cover those residents with documented or</p>	0 510		

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0 510	Continued From page 8 suspected infection with highly transmissible or epidemiologically important pathogens that require additional precautions to prevent transmission. The practice of employees would conform with OSHA regulations, current law and currently accepted health care, medical and nursing standards of practice for infection control. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 510		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by	0 660		

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0 660	<p>Continued From page 9</p> <p>the Centers for Disease Control and Prevention (CDC), which included a completed health history and symptom screening and a two-step tuberculin skin test (TST) or other evidence of TB screening, such as a blood test, for two of two employees (clinical nurse supervisor (CNS)-C, unlicensed personnel (ULP)-D).</p> <p>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).</p> <p>The findings include:</p> <p>The licensee's Facility TB Risk Assessment, dated September 1, 2024, indicated the facility was at a low risk for TB transmission.</p> <p>CNS-C CNS-C was hired May 1, 2025, to provide oversight and guidance to staff and provide direct care and services to residents of the facility.</p> <p>On May 13, 2025, at 8:35 a.m., CNS-C was observed orientating staff during a medication administration and interacting directly with residents residing in the facility.</p> <p>CNS-C's employee record indicated a TB Gold Plus (Quantiferon) test, taken on May 5, 2025. The test result, dated May 8, 2025, was negative. The record lacked documentation of a history and symptom screening completed upon hire, prior to working with residents.</p>	0 660		

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(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
0 660	<p>Continued From page 10</p> <p>ULP-D ULP-D was hired on May 5, 2025, to provide direct care and services to the residents of the facility.</p> <p>On May 13, 2025, at 8:35 a.m., ULP-D was observed assisting R1 with medication administration.</p> <p>On May 13, 2025, at 11:30 a.m., ULP-D was observed preparing and providing the lunch-time meal to residents of the facility.</p> <p>ULP-D's employee record included documentation of a TB blood test dated, June 22, 2024. ULP-D's employee record lacked documentation of a baseline TB test completed within 90 days prior to hire, and a history and symptom screening completed upon hire, prior to working with residents.</p> <p>On May 12, 2025, at approximately 11:30 a.m., during the entrance conference, CNS-C stated they would send an employee for TB testing if they did not have a test completed within 90 days before being hired. CNS-C further stated they screen yearly for signs and symptoms of TB.</p> <p>On May 13, 2025, at 1:15 p.m., CNS-C stated they did not complete a history and symptom screening upon hire, prior to working with residents.</p> <p>On May 15, 2025, at 8:15 a.m., licensed assisted living director (LALD)-A stated ULP-D was needed to provide direct care for residents immediately upon hire, therefore the licensee used an "old" Quantiferon test from a prior place of employment. LALD-A stated, in the future, the licensee needed to ensure all employees were</p>	0 660		

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0 660	<p>Continued From page 11</p> <p>screened and tested for TB prior to providing direct care to residents of the facility to make certain all residents were at the lowest possible risk for contracting TB.</p> <p>The CDC's document titled Clinical Testing Guidance for Tuberculosis: Health Care Personnel dated December 15, 2023, indicated all health care personnel should be screened for TB upon hire. TB screening includes a baseline individual TB risk assessment, TB symptom evaluation, TB test which included a TB blood Test or TB skin test.</p> <p>The licensee's Tuberculosis Screening /Prevention policy, effective January 25, 2025, indicated the licensee would observe the recommended precautions related to TB prevention as identified by the CDC and the Minnesota Department of Health (MDH). The precautions included a risk assessment, TB screening and staff education to reduce the risk for exposure to persons who may have had TB disease and would include:</p> <ul style="list-style-type: none"> -baseline TB screening at the time of hire is required for all healthcare workers in Minnesota -TB screening would consist of three components: assessing for current symptoms of active TB disease, assessing TB history and TB testing for the presence of infection with Mycobacterium by administering either a two-step TST or single TB blood test. -TB screening of all paid and unpaid health care workers was documented. All reports or copies of TST, blood tests, medical evaluation history and symptom screen, and chest radiograph results were maintained in the health care worker's employee file. Baseline screening included two-step skin testing (unless the TB blood test was used). 	0 660		

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0 660	Continued From page 12 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	<p>144G.42 Subd. 10 Disaster planning and emergency preparedness</p> <p>(a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency</p>	0 680		

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0 680	<p>Continued From page 13</p> <p>preparedness plan (EPP) with all the required content. This had the potential to affect all current residents, staff, and visitors.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>The licensee's emergency preparedness plan (EPP), undated, lacked customization to the facility, and lacked the following required content:</p> <ul style="list-style-type: none"> -be updated annually, must document date of review and any updates made to the plan based on the review. -written documentation of risk assessment -consider hazards like care related emergencies, equipment/utility failures, interruptions in communications/cyber-attacks, loss of all or portion of a facility, interruption to normal supply of essential resources and medical supplies -categorize the various probable risks/hazards by likelihood of occurrence -take an all-hazards approach, including EIDs, as applicable; -develop strategies for addressing facility & community-based risks (i.e.: evacuation plans, staffing surges/shortages, back-up plans). -consider duration of interruptions. -identify at risk population needs like maintaining independence, communication, transportation, supervision and medical care. -procedures for tracking of staff and residents. 	0 680		

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0 680	<p>Continued From page 14</p> <ul style="list-style-type: none"> -develop P/P for system to track the location of on-duty staff and sheltered residents. -identify which staff would assume specific roles in another's absence through succession planning and delegation of authority. -arrangements/contracts to re-establish utility services. -include a process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response. -EP includes policies and procedures (P/P) for, at minimum food, water, and pharmaceutical supplies -EP includes P/P for alternate sources of energy -EP includes P/P related to sewage/waste disposal. -EP includes P/P comprehensive communication plan -EP includes P/P addressing volunteers -EP includes P/P 1135 waiver <p>On May 15, 2025, at 8:15 a.m., licensed assistant living director (LALD)-A stated the licensee attempted to do their best but there was more to it than they were aware of. LALD-A stated the licensee would correct their EPP to ensure the safety of their residents and staff</p> <p>The Emergency Preparedness /CMS State Operations Manual Appendix Z; MN Rules 4659.0100 policy, dated January 25, 2025, indicated the licensee would have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupted services. The plan considered the organization ' s commitment to provide services while ensuring the safety of its employees and residents. The licensee would implement the emergency management program as soon as the agency</p>	0 680		

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0 680	Continued From page 15 became aware of the existence of an emergency. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=E	144G.45 Subd. 2 (a) (1) Fire protection and physical environment 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 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 provide smoke alarms with proper power	0 780		

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0 780	<p>Continued From page 16</p> <p>supply. This had the potential to directly affect all residents, staff, and visitors.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).</p> <p>Findings include:</p> <p>On May 13, 2025, from approximately 10:45 a.m. to 11:52 a.m., the surveyor toured the facility with licensed assisted living director (LALD)-A and LALD-B. During the tour, the surveyor observed the following deficient conditions:</p> <p>The smoke alarm provided in resident room 4 was beeping when observed during the survey, and did not respond properly when tested. The smoke alarm power supply was not sufficient and when LALD-A tested the alarm it indicated that the battery was dead. LALD-A acknowledged the alarm was not operational. Smoke alarms must be maintained in proper working order and are required to be functional when tested.</p> <p>TIME PERIOD FOR CORRECTION: Two (2) days</p>	0 780		
0 800 SS=F	<p>144G.45 Subd. 2 (a) (4) Fire protection and physical environment</p> <p>(4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds,</p>	0 800		

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0 800	<p>Continued From page 17</p> <p>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.</p> <p>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, staff, and visitors.</p> <p>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).</p> <p>The findings include:</p> <p>On May 13, 2025, from approximately 10:45 a.m. to 11:52 a.m., the surveyor toured the facility with licensed assisted living director (LALD)-A and LALD-B. During the tour, the surveyor observed the following deficient conditions:</p> <p>The electrical outlet behind the desk in the front office showed significant burn marks and damage. Damaged outlet present risk of fire or electrocution and should be repaired and maintained in proper working order. LALD-B stated that they had just noticed the outlet issues</p>	0 800		

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0 800	<p>Continued From page 18</p> <p>on the day of the survey and would have the receptacle replaced.</p> <p>The deck attached to resident room 3 had significantly rotten and decayed wood that compromised safety of the deck. There are several holes that have formed in the deck floor where the wood has eroded and cracked. The deck should be maintained in a safe manner with rotten wood removed and replaced and free of holes or damage that could cause a trip or fall. LALD-A stated they had just become aware of the condition of the deck on the day of survey and would have someone come out to make repairs.</p> <p>The rear patio of the facility had areas with rotten and decayed wood that compromised the safety of the surface. The rotten boards sank in and were not properly attached which could lead to a trip or fall. The patio should be maintained in a safe manner with the rotten wood replaced and made safe and sturdy. LALD-A stated they had just become aware of the condition of the patio on the day of survey and would have someone come out to make repairs.</p> <p>The cabinet under the sink in the basement bathroom was wet, damaged and dirty. The base of the cabinet appeared to be sinking in due to water damage and the cabinet was not maintained in proper sanitary condition. The bathroom surfaces and cabinet should be maintained in clean and sanitary condition.</p> <p>The cabinet in the bathroom of resident room 1 was sullied and dirty. The cabinet had small black pellets that appeared similar to rodent droppings. LALD-B stated that the debris was dead fruit flies. The bathroom surfaces and cabinet should be maintained in clean and sanitary condition.</p>	0 800		

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0 800	<p>Continued From page 19</p> <p>The cabinet base of the main level bathroom was very dirty with evidence of water damage, and the base of the cabinet was missing. The bathroom surfaces and cabinet should be maintained in clean and sanitary condition.</p> <p>The caulking around the toilet in the main level bathroom was deteriorated and there were gaps around the toilet that were not properly sealed. Bathroom flooring should be maintained in proper condition and watertight.</p> <p>The side gate of the property had become detached from the lower hinge, with the gate hanging from the top hinge. Operation of the gate required the gate to be dragged along the ground below requiring significant effort. The lower hinge had exposed screws that were hanging loose and could scratch or catch the clothes of someone passing through the opening. The gate should be maintained in a proper manner that is readily openable and functional without risk of injury.</p> <p>The closet door in resident room 2 had become dislodged from the track and was not readily functional.</p> <p>The front door jamb was damaged and missing the top piece of the frame, which was located on the ground near the area.</p> <p>The closer on the screen door was hanging loose and not properly connected to the screen door in the front entry.</p> <p>During the facility tour interview on May 13, 2025, LALD-A and LALD-B verified the above listed physical environment observation while accompanying on the tour and indicated they</p>	0 800		

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0 800	Continued From page 20 understood requirements. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at 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.	0 810		

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0 810	<p>Continued From page 21</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with required content and provide required training and documentation. This had the potential to directly affect all residents, staff, and visitors.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>On May 13, 2025, at approximately 11:30 a.m., licensed assisted living director (LALD)-A and LALD-B provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training.</p> <p>The licensee's FSEP failed to include the following:</p> <p>The FSEP did not include any maps or information that included the location and number of resident rooms. There were not facility diagrams in the FSEP documents, and no such diagrams were provided on the walls of the facility.</p> <p>The FSEP did not include employee actions to be taken in event of a fire or similar emergency. The</p>	0 810		

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0 810	<p>Continued From page 22</p> <p>FSEP should include the specific plan of actions that employees would take in event of an emergency at the facility.</p> <p>The FSEP did not include fire procedures for residents. The FSEP should include plans for residents to follow during evacuation.</p> <p>The FSEP did not include procedures for the resident movement, evacuation, or relocation during a fire or similar emergency including the identification of the unique or unusual resident needs for movement or evacuation. The FSEP should include information regarding specific needs of residents during evacuation.</p> <p>The FSEP did not include any documentation of trainings provided to employees on the FSEP. Employees should receive training on the FSEP upon hire and at least twice a year thereafter.</p> <p>The FSEP did not include any documentation of trainings provided to residents on evacuation. Trainings should be made available to residents capable of assisting in their evacuations at least once a year.</p> <p>Evacuation drill logs were provided showing that evacuation drills have not occurred during overnight shifts and several drills did not have the correct dates or times recorded. Evacuation drills should occur at least twice per year per shift and at least once every other month.</p> <p>During the record review and interview on May 13, 2025, LALD-A and LALD-B verified the above listed documents were incomplete within the FSEP. LALD-B worked with the surveyor and asked questions to understand requirements. LALD-B stated that they understood requirements</p>	0 810		

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0 810	Continued From page 23 and would update the existing FSEP with missing information and documents. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01620 SS=D	<p>144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring</p> <p>(c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment.</p> <p>(d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review.</p> <p>(e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing</p>	01620		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38523	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/15/2025
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NAME OF PROVIDER OR SUPPLIER GUARDIAN CARE HOMES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7221 FIRST AVENUE SOUTH RICHFIELD, MN 55423
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(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
01620	<p>Continued From page 24</p> <p>resident monitoring and reassessments not to exceed 90 calendar days from the last date of the assessment or as needed upon a change of condition for one of two residents (R1).</p> <p>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 resident are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).</p> <p>The findings include:</p> <p>R1 had diagnoses including schizophrenia, diabetes mellitus type 2, psychosis, post-traumatic stress syndrome, depression with anxiety, and bipolar disease.</p> <p>R1's Service Plan Agreement dated, July 22, 2024, indicated R1 received services including assistance with dressing, hygiene, grooming, toileting, bathing, transfers, mobility, housekeeping, laundry, and medication reminders and administration, insulin administration and behavior management.</p> <p>On May 13, 2025. at 8:35 a.m., ULP-D was observed assisting R1 with medication administration.</p> <p>R1's medical record included an assessment completed November 24, 2024. The next comprehensive nurse assessment was completed March 13, 2025, greater than 90 days (109 days) after the previous assessment.</p>	01620		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38523	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/15/2025
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NAME OF PROVIDER OR SUPPLIER GUARDIAN CARE HOMES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7221 FIRST AVENUE SOUTH RICHFIELD, MN 55423
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(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
01620	<p>Continued From page 25</p> <p>On May 12, 2025, at 2:45 p.m., clinical nurse supervisor, (CNS)-C, stated R1 had several emergency room visits since admission. CNS-C explained some of the assessments were labeled incorrectly which may have caused the 90-day assessment to be missed.</p> <p>The licensee's Assessment and Reassessment policy, dated January 25, 2025, indicated ongoing resident reassessments must be conducted by an RN and cannot exceed 90 days from the last date of assessment. The policy further indicated ongoing resident monitoring must be conducted as needed based on changes in the needs of the resident.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	01620		
01890 SS=D	<p>144G.71 Subd. 20 Prescription drugs</p> <p>A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medications were maintained including the opened date for time sensitive medication storage for one of two residents (R1).</p>	01890		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38523	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/15/2025
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NAME OF PROVIDER OR SUPPLIER GUARDIAN CARE HOMES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7221 FIRST AVENUE SOUTH RICHFIELD, MN 55423
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(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
01890	<p>Continued From page 26</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).</p> <p>The findings include:</p> <p>R1 had diagnoses including diabetes mellitus type 2.</p> <p>R1's Service Plan Agreement dated, July 22, 2024, indicated R1 received services including assistance with insulin administration.</p> <p>The medication administration record (MAR) dated May 1, 2025, through May 12, 2025, indicated R1 received Lantus (long-acting insulin, for diabetes) Solostar 100U/ML (units per milliliter) by injection subcutaneously, at 6:00 a.m., each day.</p> <p>On May 13, 2025. at 8:35 a.m., unlicensed personnel (ULP)-D was observed assisting R1 with medication administration. The surveyor observed R1's medication included an opened Lantus multi-dose injection pen. The pen was not labeled with the date staff first used the insulin, to determine when the insulin would expire. ULP-D stated they were not aware how long the insulin pen was good, once opened. ULP-D stated they were not instructed to label any medications when opened.</p> <p>The manufacturer's instructions for the use of the Lantus Solostar pen dated, August 2022, directed for the insulin to be discarded 28 days after being</p>	01890		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38523	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/15/2025
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NAME OF PROVIDER OR SUPPLIER GUARDIAN CARE HOMES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7221 FIRST AVENUE SOUTH RICHFIELD, MN 55423
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(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
01890	<p>Continued From page 27</p> <p>opened.</p> <p>On May 15, 2025, at 8:15 a.m., clinical nurse supervisor (CNS)-C stated all time sensitive medications should be labeled with the date the medication should be discarded, CNS-C stated the licensee would contact pharmacy for labels to attach to the medications. CNS-C also stated the licensee would educate staff who administered medications to the residents and also "start to educate" on labelling time-sensitive medications.</p> <p>The licensee's Storage/Control of Medication policy dated January 25, 2025, indicated medications would be stored consistent with manufacturer's recommendations and the licensed nurse was responsible for dating time-sensitive medications when opened.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	01890		



Rochester District Office
Minnesota Department of Health
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Phone: 651-201-4500

Food & Beverage Inspection Report

Page: 1

Establishment Info

Guardian Care Homes Inc
7221 First Avenue S
Richfield, MN 55423
Hennepin County
Parcel:

Phone:
jaden@bjlogistics.us

License Info

License: HFID 38523
Jawahir Aden
Risk:
License:
Expires on:
CFPM:
CFPM #: ; Exp:

Inspection Info

Report Number: F8044251017
Inspection Type: Full - Single
Date: 5/14/2025 Time: 10:42:20 AM
Duration: 60 minutes
Announced Inspection: Yes
Total Priority 1 Orders: 1
Total Priority 2 Orders: 2
Total Priority 3 Orders: 0
Delivery: Emailed

New Order: 4-300 Equipment Numbers and Capacities

4-302.12A *Priority Level: Priority 2 CFP#: 36*

MN Rule 4626.0705A Provide a readily accessible food temperature measuring device to ensure attainment and maintenance of food temperatures.

COMMENT: No thermometer on site.

Staff indicated that a new thermometer was purchased.

Comply By: 5/14/2025 Originally Issued On: 5/14/2025

New Order: 4-300 Equipment Numbers and Capacities

4-302.13A *Priority Level: Priority 2 CFP#: 48*

MN Rule 4626.0710A Provide a readily accessible temperature measuring device for measuring the washing and sanitizing temperatures in manual warewashing operations.

COMMENT: No thermometer or stickers for dishwasher.

Staff indicated that a new thermometer will be purchased.

Comply By: 5/14/2025 Originally Issued On: 5/14/2025

! New Order: 4-500 Equipment Maintenance and Operation

4-501.115B *Priority Level: Priority 1 CFP#: 16*

MN Rule 4626.0805B Discontinue using a sanitizer concentration that exceeds the EPA approved manufacturer's label amount.

COMMENT: Clorox wipes used to wipe counters are not approved for food-contact surfaces.

Chlorine bleach spray bottle will be used going forward.

Comply By: 5/14/2025 Originally Issued On: 5/14/2025

Food & Beverage General Comment

HRD inspection conducted with nurse evaluator Mary Bruess. Inspection report reviewed on site with Sudi.

Domestic kitchen consists of tile floors, painted gypsum walls and ceilings, wooden hollow-base cabinets, granite counters, and domestic equipment.

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans

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

I acknowledge receipt of the Rochester District Office inspection report number F8044251017 from 5/14/2025



Jawahir Aden

Michael DeMars,
Public Health Sanitarian III
507-206-2715
michael.demars@state.mn.us



Rochester District Office
Minnesota Department of Health
3425 40th Avenue NW, Suite 115
Rochester, MN 55901

Temperature Observations/Recordings

Page: 1

Establishment Info

Guardian Care Homes Inc
Richfield
County/Group: Hennepin County

Inspection Info

Report Number: F8044251017
Inspection Type: Full
Date: 5/14/2025
Time: 10:42:20 AM

Food Temperature: Product/Item/Unit: Cole slaw; **Temperature Process:** Cold-Holding

Location: Refrigerator at 34.4 Degrees F.

Comment:

Violation Issued?: No

Equipment Temperature: Product/Item/Unit: ; Temperature Process: Cold-Holding

Location: Refrigerator at 31.0 Degrees F.

Comment:

Violation Issued?: No



Rochester District Office
Minnesota Department of Health
3425 40th Avenue NW, Suite 115
Rochester, MN 55901

Sanitizer Observations/Recordings

Page: 1

Establishment Info

Guardian Care Homes Inc
Richfield
County/Group: Hennepin County

Inspection Info

Report Number: F8044251017
Inspection Type: Full
Date: 5/14/2025
Time: 10:42:20 AM

Sanitizing Equipment: Product: Hot Water; **Sanitizing Process:** Dish Machine

Location: Kitchen **Equal To** 161.4 Degrees F.

Comment:

Violation Issued?: No