Electronically Delivered

November 21, 2025

Licensee
Presbyterian Homes Of Bloomington
9889 Penn Avenue South
Bloomington, MN  55431

RE: Project Number(s) SL24062016

Dear Licensee:

On November 20, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on September 18, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

KKM

Electronically Delivered

October 28, 2025

Licensee
Pres Homes Of Bloomington
9889 Penn Avenue South
Bloomington, MN 55431

RE: Project Number(s) SL24062016-0

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 18, 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.

**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;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, 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:

**0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00**
**0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00**
**2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $1,000.00**

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $2,000.00**. 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.

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,

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

JMD

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24062 | A. BUILDING: _____ B. WING _____ | 09/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PRES HOMES OF BLOOMINGTON | 9889 PENN AVENUE SOUTH BLOOMINGTON, MN 55431 |

| (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 |
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| 0 000 | Initial Comments<br><br>*****ATTENTION*****<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.<br><br>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.<br><br>INITIAL COMMENTS:<br><br>SL24062016-0<br><br>On September 15, 2025, through September 18, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 90 residents receiving services under the Assisted Living Facility with Dementia Care license.<br><br>On September 18, 2025, an immediate correction order was issued for tag identification 2310.<br><br>During the course of the survey, the licensee took action to mitigate the imminent risk. Noncompliance remained and the scope and level remain unchanged. | 0 000 | Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3. | |
| 0 480 SS=F | 144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services | 0 480 | | |

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| 0 480 | Continued From page 1<br><br>(a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626.<br>(b) For an assisted living facility with a licensed capacity of ten or fewer residents:<br>(1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation;<br>(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;<br>(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;<br>(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;<br>(5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, | 0 480 | | |

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| 0 480 | Continued From page 2<br><br>existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition;<br>(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<br>(7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated September 15, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee | 0 480 | | |

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| 0 480 | Continued From page 3<br>within 24 hours of the inspection.<br><br>TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates. | 0 480 | | |
| 0 510 SS=F | 144G.41 Subd. 3 Infection control program<br><br>(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.<br>(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.<br>(c) The facility must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program that complies with accepted health care, medical and nursing standards for infection control related to hand hygiene and use of PPE (personal protective equipment) for two of two unlicensed personnel ((ULP)-A, ULP-B).<br><br>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 | 0 510 | | |

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| 0 510 | Continued From page 4<br>failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>ULP-A<br>On September 16, 2025, at 9:59 a.m., the surveyor observed ULP-A go into R7's room to assist R7 with the administration of a topical analgesic (acts to relieve pain) medication to R7's bilateral knees and hip. The surveyor observed ULP-A don (put on) gloves without performing hand hygiene before the administration of the topical analgesic medication. After the administration of the topical analgesic medication, the surveyor observed ULP-A assist R7 to a common living room area while wearing the same gloves. While ULP-A was assisting R7, ULP-A had observed another resident in the common living room area stand up without their assisted device, ULP-A told the other resident they needed to use their walker and then grabbed the other resident's walker while wearing the same gloves and moved it to that resident. ULP-A then proceed to assist R7 again with ambulation until another staff took over for ULP-A to assist R7 with ambulation. ULP-A then grabbed a magazine that was in the common area and gave the magazine to R7 while wearing the same gloves. ULP-A then doffed (removed) the gloves without performing hand hygiene. ULP-A returned to R7's room where they donned gloves again without performing hand hygiene, gathered the topical analgesic medication that was left in R7's room, then went to the common medication room that was next to R7's room and placed the medication in R7's locked medication tote. ULP-A doffed gloves without performing hand hygiene. | 0 510 | | |

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| 0 510 | Continued From page 5<br><br>On September 16, 2025, following the surveyor's observations at 9:59 a.m., ULP-A stated they had been trained and completed a competency evaluation by a nurse for hand washing and glove use. ULP-A confirmed they did not was their hands during the surveyor's observation; and stated they should have washed their hands before and after glove use.<br><br>ULP-A's New Hire RA Skills Competency dated February 4, 2025, indicated ULP-A was competent in hand washing and PPE.<br><br>ULP-B<br>On September 16, 2025, at 11:04 a.m., the surveyor observed ULP-B in the hallway with R8 using a gait belt and walker. ULP-B stated R8 had completed their exercise and now needed to use the bathroom. The surveyor observed ULP-B go into R8's bathroom in R8's room. ULP-B donned gloves without performing hand hygiene. ULP-B assisted R8 with undressing and transferred R8 onto the toilet. ULP-B changed an incontinence pad, performed peri care (cleaning of the private parts) on R8, applied barrier cream to R8's buttocks, and then assisted R8 with dressing again after use of the toilet. ULP-B then doffed the gloves without performing hand hygiene and assisted R8 into R8's recliner in R8's room. ULP-B proceeded to get R8's locked medication tote from R8's closet. ULP-B then washed their hands at the sink in R8's room. ULP-B reviewed R8's medication administration record and stated R8 needed to have their vital signs checked. ULP-B left R8's room and went to common laundry room where the vital sign equipment was located. ULP-B returned to R8's room with the vital sign equipment and donned | 0 510 | | |

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| 0 510 | Continued From page 6<br><br>gloves without performing hand hygiene. ULP-B checked R8's blood pressure and heart rate. ULP-B doffed the gloves, washed hands using soap, and then donned new gloves. ULP-B unlocked R8's medication tote, prepared R8's medications to be given in a disposable medication cup and then doffed the gloves without performed hand hygiene. ULP-B gave the prepared medications to R8 for administration and assisted R8 in a laying position in R8's recliner. ULP-B did not perform hand hygiene upon leaving R8's room.<br><br>ULP-B's New Hire RA Skills Competency dated July 22, 2025, indicated ULP-B was competent in hand washing and PPE.<br><br>On September 18, 2025, at 2:28 p.m., clinical nurse supervisor (CNS)-D stated all staff should wash hands before/after use of gloves and before/after cares. CNS-D stated staff have been trained on handwashing and glove use. CNS-D stated they often talk about hand washing and glove use at their routine stand up meetings.<br><br>The licensee's undated Hand Hygiene policy indicated hand hygiene should be performed:<br>- before and after contact with the resident;<br>- before performing an aseptic (medically clean or without infection) task;<br>- after contact with blood or body fluids;<br>- after contact with visibly contaminated surfaces;<br>- after contact with objects in the resident's room;<br>- before donning personal protective equipment;<br>- after removing personal protective equipment;<br>- after using the restroom; and<br>- before meals.<br><br>The licensee's undated Glove Technique | 0 510 | | |

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| 0 510 | Continued From page 7<br><br>(non-sterile) policy indicated to apply clean non-sterile gloves when touching blood, body fluids, secretions, excretions, contaminated items, mucous membranes, and non-intact skin. Don clean gloves between tasks and procedures on the same resident after contact with blood, body fluids, secretions, excretions. Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces. Perform hand hygiene after the removal of gloves.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 510 | | |
| 0 775 SS=F | 144G.45 Subd. 2. (a) Fire protection and physical environment<br><br>Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to comply with the current State Fire Code in Minnesota Rules, chapter 7511. This had the potential to directly affect all residents, staff, and visitors.<br><br>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 | 0 775 | | |

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| 0 775 | Continued From page 8<br><br>failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>Findings include:<br>On September 18, 2025, from 2:30 p.m. to 5:30 p.m., the surveyor toured the facility with regional engineer manager (REM)-F and environmental services director (ESD)-G. During the tour, the surveyor observed:<br><br>SMOKE ALARMS:<br>Facility has installed hard-wired smoke alarms in each resident room. In the 25+ surveyed rooms alarms were over 10 years past the manufacturer date. Per MN State Fire Code and manufacturer's instructions, single-and multiple-station smoke alarms shall be replaced when they exceed ten years from the date of manufacture. All smoke alarms shall be replaced with smoke alarms having the same type of power supply.<br><br>CONTROLLED EGRESS<br>Controlled egress doors in the memory care area, had a separate switch to override the system. When that system was tested during the survey, the system failed to operate. MN Fire code states, egress control locking systems shall have the capability of being unlocked by a signal or switch from the fire command center, a nursing station, or other approved location. The signal or switch shall directly break power to the lock.<br><br>During a facility tour on September 15, 2025, at 4:30 p.m., REM-F/ESD-G, verified the above listed observations while accompanying on the tour. | 0 775 | | |

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| 0 775 | Continued From page 9<br>TIME PERIOD FOR CORRECTION: Two (2) day. | 0 775 | | |
| 01060 SS=F | 144G.52 Subd. 9 Emergency relocation<br><br>(a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination.<br>(b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum:<br>(1) the reason for the relocation;<br>(2) the name and contact information for the location to which the resident has been relocated and any new service provider;<br>(3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities;<br>(4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and<br>(5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal.<br>(c) The notice required under paragraph (b) must be delivered as soon as practicable to:<br>(1) the resident, legal representative, and designated representative;<br>(2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case | 01060 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24062 | A. BUILDING: _____ B. WING _____ | 09/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| 01060 | Continued From page 10<br><br>manager; and<br>(3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days.<br>(d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, or designated representative for one of one resident (R2).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>R2 was admitted to the licensee on February 20, 2025, with a diagnosis of hypertension (high Bbood pressure).<br><br>R2's service plan dated July 8, 2025, indicated R2 received assistance with medication management and a treatment for compression stockings.<br><br>R2's progress note dated July 28, 2025, at 8:59 | 01060 | | |

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| 01060 | Continued From page 11<br><br>a.m., indicated R2 had called 911 and was transferred to hospital where R2 was admitted under observation due to chest tightness. R2 had an emergency relocation due to an urgent medical need.<br><br>R2's record lacked documentation of R2 or R2's designated representative received a written emergency relocation notice with all required content for each emergency relocation.<br><br>In an email dated September 18, 2025, at 12:52 p.m., licensed assisted living director (LALD)-C indicated documentation for an emergency relocation on R2 had not been completed since R2 was only in hospital for three days (July 26, 2025, thru July 28, 2025).<br><br>On September 18, 2025, at 2:28 p.m., clinical nurse supervisor (CNS)-D stated the licensee's process was for the director to send out the emergency relocation notification if the resident would be out of the facility for four or more days.<br><br>On September 18, 2025, at 2:40 p.m., LALD-C stated the licensee's process had been if the resident were to be out of the facility for four or more days, then they would send out the written notification to the resident, family, case manager, and the ombudsman. The surveyor explained the statue to LALD-C, who then stated they had a better understanding of the statue.<br><br>The licensee's Housing Termination, Relocation, and Transfer policy dated July 18, 2025, under emergency relocation, indicated the facility must provide a written notice, as soon as practical and would include the following:<br>- the reason for the relocation; | 01060 | | |

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|---|---|---|---|---|
| 01060 | Continued From page 12<br><br>- the name and contact information for the location to which the resident has been relocated and any new service provider;<br>- contact information for the Office of Ombudsman for Long-Term Care;<br>- if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and<br>- a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01060 | | |
| 01530 SS=D | 144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De-<br><br>(a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements:<br>(1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; | 01530 | | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| 01530 | Continued From page 13<br><br>(2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter;<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure all employees received eight hours of initial dementia care training that included all of the required topics within the first 160 working hours of employment for direct care employees as required for one of two unlicensed personnel ((ULP)-B).<br><br>This practice resulted in a level two violation (a | 01530 | | |

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| 01530 | Continued From page 14<br><br>violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).<br><br>The findings include:<br><br>On September 16, 2025, at 8:57 a.m., the surveyor observed ULP-B assist R6 with a treatment for compression stockings in R6's room without any other staff present.<br><br>ULP-B was hired on July 21, 2025, as a resident assistant.<br><br>ULP-B's transcript included the following dementia care training for a total of 7.5 hours:<br>- DOVE workshop (4 hours);<br>- Dementia Care: supporting Families (1 hour);<br>- About Alzheimer's Disease and Dementia (1 hour);<br>- Introduction to Dementia 100 (0.5 hours);<br>- Dementia Care: Performing ALDs (0.5 hours); and<br>- Preventing Adverse Reactions to Dementia Care (0.5 hours).<br><br>ULP-B's personnel record lacked the initial required dementia care training on problem solving with challenging behaviors.<br><br>On September 17, 2025, at 1:17 p.m., licensed assisted living director (LALD)-C confirmed ULP-B had worked a total of 346.75 hours since their hire date for the licensee. | 01530 | | |

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|---|---|---|---|
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| 01530 | Continued From page 15<br><br>On September 18, 2025, at 2:50 p.m., LALD-C stated staff should have completed all assigned dementia training which included problem solving with challenging behaviors.<br><br>On September 18, 2025, at 3:40 p.m., in an email, LALD-C confirmed ULP-B did not complete the initial required dementia care training on problem solving with challenging behaviors.<br><br>The licensee's Dementia, Mental Illness, De-Escalation, and Behavioral Health Training policy dated June 1, 2025, indicated dementia training would be included in the initial orientation; and the training would include problem solving with challenging behaviors. The policy indicated employees who had not completed the initial dementia training would not provide direct care independently.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01530 | | |
| 01620 SS=E | 144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring<br><br>(a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment.<br>(b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on | 01620 | | |

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| 01620 | Continued From page 16<br>which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery.<br>(c) Resident reassessment and monitoring must be conducted by a registered nurse:<br>(1) no more than 14 calendar days after initiation of services;<br>(2) as needed based on changes in the resident's needs; and<br>(3) at least every 90 calendar days.<br>(d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment.<br>(e) 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.<br>(f) 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 | 01620 | | |

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|---|---|---|---|---|
| 01620 | Continued From page 17<br>resident moves in, whichever is earlier.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure reassessment and monitoring were completed no more than fourteen calendar days after initiation of services and not to exceed ninety calendar days from previous assessment for three of four residents (R2, R3, R4).<br><br>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 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).<br><br>The findings include:<br><br>R2<br>R2 was admitted to the licensee on February 20, 2025, with diagnosis of hypertension (high Blood pressure).<br><br>R2's Service Plan - Attachment E to Residency Agreement dated July 8, 2025, indicated R2 received assistance with medication management and a treatment for ted hose/ace wrap/Velcro leg wrap.<br><br>R2's record included a fourteen-day nursing assessment completed on March 6, 2025; a ninety-day assessment completed on June 4, | 01620 | | |

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|---|---|---|---|
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| 01620 | Continued From page 18<br><br>2025; and a bed device assessment on June 10, 2025, and again on September 16, 2025 (after the initiation of survey). The assessment completed on June 10, 2025, indicated a reassessment should have been completed on or before September 8, 2025. The assessment completed on September 16, 2025, was 98 days after the last assessment completed on June 10, 2025.<br><br>R3<br>R3 was admitted to the licensee on August 15, 2024, with diagnosis of unspecified atrial fibrillation (irregular and often rapid heart rhythm).<br><br>R3's Service Plan - Attachment E to Residency Agreement dated May 21, 2025, indicated R3 received assistance with medication administration.<br><br>R3's record included a fourteen-day nursing assessment completed on August 30, 2024; and ninety-day nursing assessment completed on February 19, 2025, May 21, 2025, and July 31, 2025. The fourteen-day assessment completed on August 30, 2024, indicated the fourteen-day assessment was completed fifteen days after the initiation of services. The ninety-day assessment completed on February 19, 2025, indicated a reassessment should have been completed on or before May 20, 2025. The assessment completed on May 21, 2025, indicated the assessment was one day late.<br><br>R4<br>R4 was admitted to the licensee on September 13, 2022, with diagnosis of dementia. | 01620 | | |

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|---|---|---|---|
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| 01620 | Continued From page 19<br><br>R4's Service Plan - Attachment E to Residency Agreement dated July 25, 2025, indicated R4 received assistance with medication administration.<br><br>R4's record included ninety-day assessments dated February 25, 2025, May 19, 2025, and August 19, 2025. The ninety-day assessment completed on May 19, 2025, indicated a reassessment should have been completed on or before August 17, 2025. The assessment completed on August 18, 2025, indicated the assessment was one day late.<br><br>On September 18, 2025, at 12:04 p.m., clinical nurse supervisor (CNS)-D stated over the last few months the licensee had some turnover with their nurses, usually the nurses check for assessments due weekly. CNS-D stated the licensee had been in the process of getting caught up; and they tried their best to make sure they were done timely and not late.<br><br>The licensee's MN AL Nursing Assessment policy dated May 3, 2022, indicated a fourteen-day assessment would be completed up to fourteen days after the initiation of services and ongoing re-assessments would be completed periodically but no less then every ninety days. The policy did not indicate a re-assessment could not exceed ninety days from the last assessment.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01620 | | |
| 01880 SS=D | 144G.71 Subd. 19 Storage of medications | 01880 | | |

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|---|---|---|---|
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|---|---|---|---|---|
| 01880 | Continued From page 20<br><br>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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure all medications were securely locked in substantially constructed compartments and permitted only authorized personnel to have access for one of one resident (R7).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).<br><br>The findings include:<br><br>On September 16, 2025, at 9:59 a.m., the surveyor observed unlicensed personnel (ULP)-A administer R7's topical analgesic (for pain) medication in R7's room in the secured unit. After the administration of R7's topical analgesic medication, ULP-A left the medication unsecured on a table in R7's room with R7's door open while they assisted R7 to a common living room area. The common living room area was not in sight of ULP-A. Upon ULP-A returning to R7's room, the surveyor observed another staff that was identified as a housekeeper, in R7's room with | 01880 | | |

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|---|---|---|---|---|
| 01880 | Continued From page 21<br><br>R7's topical analgesic medication still on R7's table unsecured. ULP-A then grabbed the medication and went in the locked medication room where they locked the medication up in R7's medication tote.<br><br>R7 was admitted to the licensee on June 25, 2025, with diagnosis of dementia.<br><br>R7's Service Plan - Attachment E to Residency Agreement dated August 27, 2025, indicated R7 received assistance with medication administration.<br><br>R7's medication administration record (MAR) dated September 2025, indicated topical analgesic was to be administered two times per day for osteoarthritis.<br><br>R7's Assessment dated July 9, 2025, indicated R7 did not take any medications.<br><br>On September 18, 2025, at 5:12 p.m., clinical nurse supervisor (CNS)-D stated after staff have administer a medication, they should be locking the medication back up in the medication totes.<br><br>The licensee's AL Medication Management policy dated June 25, 2025, indicated provider orders would be obtained for all medications to be administered; and all medications would be stored in a locked box.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01880 | | |

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| PRES HOMES OF BLOOMINGTON | 9889 PENN AVENUE SOUTH BLOOMINGTON, MN 55431 |

| (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 | Continued From page 22 | 01890 | | |
| 01890 SS=D | 144G.71 Subd. 20 Prescription drugs<br><br>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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure expired medications were disposed of for one of one resident (R8).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).<br><br>The findings include:<br><br>On September 16, 2025, at 11:04 a.m., the surveyor observed R8's prescribed Reguloid (psyllium husk) powder with a prescription label, had an expired medication date of July 21, 2025; and was stored in R8's medication tote.<br><br>R8's medication administration record (MAR) dated September 2025, indicated R8 could have psyllium husk, dissolve one teaspoon powder in water up to twice a day as needed. | 01890 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24062 | A. BUILDING: _____ B. WING _____ | 09/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PRES HOMES OF BLOOMINGTON | 9889 PENN AVENUE SOUTH BLOOMINGTON, MN 55431 |

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|---|---|---|---|---|
| 01890 | Continued From page 23<br><br>On September 16, 2025, at 11:04 a.m., unlicensed personnel (ULP)-B stated R8 did not take that medication and had pointed to the expired Reguloid. ULP-B stated the nurse would check for expired medications in the resident rooms. ULP-B then stated they would take the expired medication to the nurse and let them know.<br><br>On September 18, 2025, at 5:12 p.m., clinical nurse supervisor (CNS)-D stated staff should pull the expired medication out; and the licensee performed weekly reviews for expired medications.<br><br>The licensee's AL Medication Management policy dated June 25, 2025, indicated a nurse would perform a weekly medication review.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01890 | | |
| 02310 SS=G | 144G.91 Subd. 4 (a) Appropriate care and services<br><br>(a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, | 02310 | During the course of the survey, the licensee took action to mitigate the imminent risk. Noncompliance remained | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24062 | A. BUILDING: _____ B. WING _____ | 09/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PRES HOMES OF BLOOMINGTON | 9889 PENN AVENUE SOUTH BLOOMINGTON, MN 55431 |

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|---|---|---|---|---|
| 02310 | Continued From page 24<br><br>medical, or nursing standards for one of two residents (R3) with consumer bed rails.<br><br>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident), 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).<br><br>The findings include:<br><br>On September 15, 2025, at 11:38 a.m., during a tour of the facility, the surveyor observed R3 had one consumer bed rail installed on their bed.<br><br>R3 was admitted on August 15, 2024.<br><br>R3's Service Plan dated May 28, 2025, indicated R3 received assistance with medication administration.<br><br>On September 16, 2025, at 8:45 a.m., the surveyor requested R3's physical device assessment (for bed rail).<br><br>R3's assessment dated September 16, 2025, indicated the reason for the assessment was due to bed assist device. The assessment was electronically signed at 12:44 p.m., which was after the surveyor had requested R3's physical device assessment for the consumer bed rail.<br><br>R3's record lacked the following documentation prior to September 16, 2025:<br>-an individualized assessment of the bed rail;<br>-the bed rails were installed, used, and | 02310 | and the scope and level remain unchanged. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24062 | A. BUILDING: _____ B. WING _____ | 09/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PRES HOMES OF BLOOMINGTON | 9889 PENN AVENUE SOUTH BLOOMINGTON, MN 55431 |

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|---|---|---|---|---|
| 02310 | Continued From page 25<br><br>maintained per manufacturer's guidelines;<br>-the manufacturer's guidelines were available upon request;<br>-review of the Consumer Product Safety Commission (CPSC) website for recalled bed rails; and<br>-the risks vs. benefits were discussed with the resident and/or responsible party.<br><br>On September 18, 2025, at 11:12 a.m., an email from clinical nurse supervisor (CNS)-D, indicated the licensee had identified R3's family had installed the bed rail according to the son, approximately around February of 2025.<br><br>On September 18, 2025, at 12:04 a.m., CNS-D stated the licensee did not have an assessment on file for the consumer bed rail prior to September 16, 2025. CNS-D stated the licensee would usually be the one to initiate a bed rail for a resident as they usually don't have situations where the family is installing bed rails. CNS-D stated R3's family did not let anyone know about the bed rail. CNS-D stated housekeeping was to notify the nurse whenever they observed a new bed rail for a resident when they cleaned a resident room. CNS-D confirmed housekeeping had documented no bed rail on September 2, 2025, and there was no documentation of a bed rail by housekeeping in the month of February when the family had installed the bed rail.<br><br>The licensee's AL Physical Device Policy dated July 31, 2024, indicated the licensee would document in the resident's clinical record at the implementation of the device or upon identification of the device by the facility staff.<br><br>According to The Minnesota Department of | 02310 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24062 | A. BUILDING: _____ B. WING _____ | 09/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PRES HOMES OF BLOOMINGTON | 9889 PENN AVENUE SOUTH BLOOMINGTON, MN 55431 |

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|---|---|---|---|---|
| 02310 | Continued From page 26<br><br>Health's (MDH) Assisted Living: Resources and Frequently Asked Questions (FAQs) website accessed on September 18, 2025, at 12:37 p.m., indicated under consumer bed rails, the licensee must assess the individual's cognitive and physical status to ensure the individual is an appropriate candidate for a bed rail; and the licensee should refer to individual manufacturer's guidelines for appropriate installation, maintenance and use. In addition, the licensee should refer to the consumer product safety commission (CSPC) for the most up-to-date information related to portable bed side rail recall information.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Immediate | 02310 | | |

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

# Food & Beverage Inspection Report



## Establishment Info

PRESBYTERIAN HOMES OF BLOOMIN
9889 PENN AVENUE SOUTH
Bloomington, MN 55431
Hennepin County
Parcel:

Phone:

## License Info

License: HFID 24062

Risk:
License:
Expires on:
CFPM: Airiana Johanns
CFPM #: 39855; Exp: 8/24/2028

## Inspection Info

Report Number: F7994251097
Inspection Type: Full - Single
Date: 9/15/2025 Time: 12:15:26 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 1
Total Priority 2 Orders: 1
Total Priority 3 Orders: 0
Delivery:

! **New Order: 3-300A Protection from Contamination: limit hand contact, tasting**
3-301.11A *Priority Level: Priority 1 CFP#: 9*
*MN Rule 4626.0225A* Discontinue bare hand contact with ready-to-eat foods. Use deli tissue, spatulas, tongs, single-use gloves or other dispensing equipment.
COMMENT: BARE HAND CONTACT OBSERVED WITH PREPPING GRAPES. ENSURE GLOVES OR OTHER EFFECTIVE MEANS ARE USED WHEN HANDLING READY TO EAT FOODS.
*Comply By: 9/15/2025 Originally Issued On: 9/15/2025*

**New Order: 4-600 Cleaning Equipment and Utensils**
4-601.11A *Priority Level: Priority 2 CFP#: 16*
*MN Rule 4626.0840A* Equipment food-contact surfaces and utensils must be clean to sight and touch.
COMMENT: CAN OPENER FOUND WITH FOOD RESIDUE BUILD UP. ENSURE IT IS WASHED AFTER EACH USE.
*Comply By: 9/15/2025 Originally Issued On: 9/15/2025*

# Food & Beverage General Comment

INSPECTION CONDUCTED IN THE PRESENCE OF HRD STAFF AND FINDINGS SHARED AT THE END OF INSPECTION.
WILL EMAIL SUPPORTING DOCUMENTS AND LINKS TO HRD STAFF AT THE END OF THE DAY.

TEMPERATURES:
SERVICE LINE
BEEF 189
SOUP 195
BROTH 193

MILK 39
MILK 40

WALK IN
BEEF 38
SOUP 39
FISH 28

BISTRO

PIZZA 135
RICE 154
SAUCE 148

SANITIZERS:

**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 Metro District Office inspection report number F7994251097 from 9/15/2025**

Airiana Johanns

Crystal Elva, REHS, MS, BS
Public Health Sanitarian 3
651-201-3981
crystal.elva@state.mn.us

Minnesota (MDH) Version
EH Manager; RPT: F7994251097

# Food Establishment Inspection Report



Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

| | | |
|---|---|---|
| No. of Risk Factor/Intervention/Violations | 2 | Date: 9/15/2025 |
| No. of Repeat Risk Factor/Intervention/Violations | | Time: 12:15:26 PM |
| Score (optional) | | Dur: min |

| Establishment: | Address: | City/State: | Zip: | Phone: |
|---|---|---|---|---|
| PRESBYTERIAN HOMES OF BLOOMING | 9889 PENN AVENUE SOUTH | Bloomington, MN | 55431 | |
| **License/Permit #:** | **Permit Holder:** | **Purpose of Inspection:** | **Est. Type:** | **Risk Category:** |
| HFID 24062 | | Full | | |

## FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Designated compliance status (IN, OUT, N/O, N/A) for each numbered item
**IN**=in compliance **OUT**=not in compliance **N/O**=not observed **N/A**=not applicable

Mark "X" in appropriate box for COS and/or R
**COS**=corrected on-site during inspection **R**=repeat violation

| | Compliance Status | | COS | R |
|---|---|---|---|---|
| | **Supervision** | | | |
| 1 | IN | Person in charge present, demonstrate knowledge and performs duties | | |
| 2 | IN | Certified Food Protection Manager | | |
| | **Employee Health** | | | |
| 3 | IN | knowledge, responsibiities, and reporting | | |
| 4 | IN | Proper use of restriction and exclusion | | |
| 5 | IN | Response to vomiting, diarrheal events | | |
| | **Good Hygienic Practices** | | | |
| 6 | IN | Proper eating, tasting, drinking, tobacco use | | |
| 7 | IN | No discharge from eyes, nose, and mouth | | |
| | **Preventing Contamination by Hands** | | | |
| 8 | IN | Hands clean and properly washed | | |
| 9 | OUT | No bare hand contact with RTE foods, alternatives | | |
| 10 | IN | Adequate handwashing sinks supplied and access | | |
| | **Approved Source** | | | |
| 11 | IN | Food obtained from approved source | | |
| 12 | N/O | Food Received at proper temperature | | |
| 13 | IN | Food in good condition, safe & unadulterated | | |
| 14 | N/A | Records available: shellstock tags, parasite dest. | | |
| | **Protection From Contamination** | | | |
| 15 | IN | Food separated and protected | | |
| 16 | OUT | Food-contact surfaces; cleaned & sanitized | | |
| 17 | IN | Proper Disposition of returned, previously served, reconditioned,& unsafe food | | |

| | Compliance Status | | COS | R |
|---|---|---|---|---|
| | **Time/Temperature Control for Safety** | | | |
| 18 | N/O | Proper cooking time & temperatures | | |
| 19 | N/O | Proper reheating procedures for hot holding | | |
| 20 | N/O | Proper cooling time and temperature | | |
| 21 | IN | Proper hot holding temperatures | | |
| 22 | IN | Proper cold holding temperatures | | |
| 23 | IN | Proper date marking & disposition | | |
| 24 | N/A | Time as public health control;procedures & record | | |
| | **Consumer Advisory** | | | |
| 25 | N/A | Consumer advisory provided for raw or undercooked foods | | |
| | **Highly Susceptible Populations** | | | |
| 26 | IN | Pasteurized foods used; prohibited foods not offered | | |
| | **Food/Color Additives and Toxic Substances** | | | |
| 27 | N/A | Food additives; approved & properly used | | |
| 28 | IN | Toxic substances properly identified;stored;used | | |
| | **Conformance with Approved Procedures** | | | |
| 29 | N/A | Compliance with variance, specialized processes & HACCP plan | | |

**Risk factors** are improper practices or procedures identified as the most prevalent contributing factors of foodborne illness or injury. Public Health Interventions are control measures to prevent foodborne illness or injury

## GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" or OUT in box if numbered item is **not** in compliance Mark "X" in appropriate box for COS and/or R **COS**=corrected on-site during inspection **R**=repeat violation

| | | | COS | R |
|---|---|---|---|---|
| | | **Safe Food and Water** | | |
| 30 | IN | Pasteurized eggs used where required | | |
| 31 | | Water & ice from approved source | | |
| 32 | N/A | Variance obtained for specialized processing methods | | |
| | | **Food Temperature Control** | | |
| 33 | | Proper cooling methods used; adequate equipment for temperature control | | |
| 34 | N/O | Plant food properly cooked for hot holding | | |
| 35 | IN | Approved thawing methods used | | |
| 36 | | Thermometers provided & accurate | | |
| | | **Food Identification** | | |
| 37 | | Food properly labeled; original container | | |
| | | **Prevention of Food Contamination** | | |
| 38 | | Insects, rodents, & animals not present; no unauthorized person | | |
| 39 | | Contamination prevented during food prep, storage, & display | | |
| 40 | | Personal cleanliness | | |
| 41 | | Wiping cloths: properly used & stored | | |
| 42 | | Washing fruits & vegetables | | |

| | | | COS | R |
|---|---|---|---|---|
| | | **Proper Use of Utensils** | | |
| 43 | | In-use utensils; Properly stored | | |
| 44 | | Utensils, equipment & linens; properly stored, dried, handled | | |
| 45 | | Single-use & single-service articles, properly stored and used | | |
| 46 | | Gloves used properly | | |
| | | **Utensils, Equipment and Vending** | | |
| 47 | | Food & non-food contact surfaces cleanable, properly designed, constructed, & used | | |
| 48 | | Warewashing facilities: installed, maintained, used; test strips | | |
| 49 | | Non-food contact surfaces clean | | |
| | | **Physical Facilities** | | |
| 50 | | Hot & cold water available; adequate pressure | | |
| 51 | | Plumbing installed; proper backflow devices | | |
| 52 | | Sewage & waste water properly disposed | | |
| 53 | | Toilet facilities; properly constructed, supplied & cleaned | | |
| 54 | | Garbage & refuse properly disposed; facilities maintained | | |
| 55 | | Physical facilities installed, maintained & clean | | |
| 56 | | Adequate ventilation & lighting; designated areas used | | |
| 57 | | Compliance with MCIAA | | |
| 58 | | Compliance with licensing and plan review | | |

Person in Charge (signature)

Inspector (signature) Crystal Elva

Follow-up: Follow-up Date: