Electronically Delivered
February 29, 2024

Licensee
Golden Path Home Care Services, LLC
2094 151st Lane Northwest
Andover, MN 55304

RE: Project Number(s) SL39726015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial survey on February 14, 2024, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

DOCUMENTATION OF ACTION TO COMPLY
Per 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 residents/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

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

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

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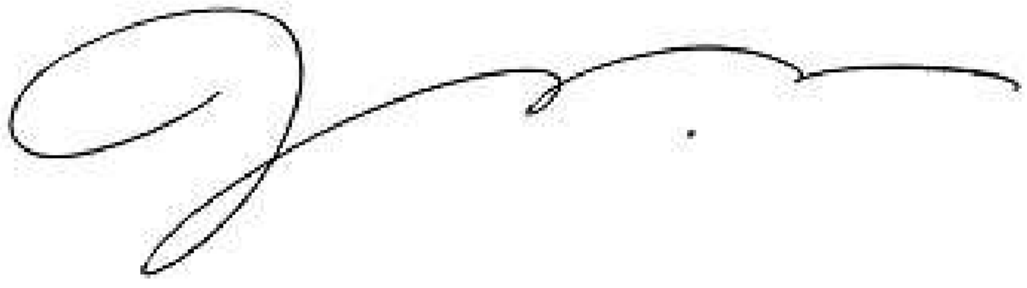
If you have any questions, please contact me.

Sincerely,



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

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39726	A. BUILDING: _____ B. WING _____	02/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN PATH HOME CARE SERVICES LLC	2094 151ST LANE NORTHWEST ANDOVER, MN 55304

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL39726015-0 On February 12, 2024, through February 14, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were two (2) residents receiving services under the Provisional Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that	0 510		

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0 510	Continued From page 1 complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complied with accepted health care, medical and nursing standards for infection control related to gloves and surfaces for one of one unlicensed personnel (ULP)-E. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On February 13, 2024, at 10:27 a.m., ULP-E provided toileting assistance to R2 with gloves on while on the toilet. When R2 stood up, ULP-E with same gloves from toileting, pulled R2's brief and pants up. ULP-E then carried the catheter bag to R2's wheelchair and placed it on the frame	0 510		

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0 510	Continued From page 2 of the wheelchair. After R2 was out of the bathroom (another staff person wheeled R2 away from the bathroom) ULP-E wiped the commode (portable toilet) with bath wipes and moved the commode to the shower area. With same gloves from toileting assistance, ULP-E used toilet bowl cleaner and toilet brush to clean the inside of the toilet. Once completed, ULP-E then removed right hand glove to grab the trash and took it out into the garage. Without washing hands, ULP-E grabbed a new pair of gloves and grabbed a bag from the kitchen island to place in the bathroom trash can. With gloves on, ULP-E opened the cabinet in the main area with keys and put the toilet bowl cleaner into the cabinet then locked it. ULP-E went back into the bathroom to wipe the counter tops with bath wipes. ULP-E went into the kitchen to remove and discard gloves and washed hands. On February 13, 2024, at approximately 10:40 a.m., ULP-E stated she was not trained to remove gloves right away after performing a task. ULP-E was also unaware that bath wipes were not a disinfectant and only to be used on skin for cleaning. On February 13, 2024, at 10:52 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-D stated all staff were trained to remove gloves and wash hands after perineal care. CNS/LALD-D stated hand sanitizer was not kept in the bathroom because she wanted staff to wash their hands after performing a task. CNS/LALD-D stated bath wipes should not be used for cleaning surfaces, and they provided disinfectant wipes. ULP-E's employee training record indicated ULP-E received infection control training on	0 510		

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0 510	Continued From page 3 February 8, 2024. The licensee's Infection Control policy dated August 1, 2021, indicated hands are to be washed immediately after gloves were removed. The licensee's Staff Orientation and Education policy dated August 1, 2021, indicated all ULPs would be trained on infection control techniques such as handwashing, use of gloves, and disinfection of environmental surfaces. The Centers for Disease Control (CDC) Hand Hygiene in Health Care Settings Healthcare Providers dated January 30, 2020, directed health care workers to wash their hands immediately before touching a [resident], after touching a patient or patient's immediate environment, after glove removal, and when hands were visibly soiled. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency	0 650		

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0 650	Continued From page 4 evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records included all required content for one of one unlicensed personnel (ULP)-B. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-B was hired on May 24, 2023, to provide direct services to residents. ULP-B's employee record lacked the following required content: - competency evaluations for care and use of hearing aids.	0 650		

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0 650	Continued From page 5 On February 13, 2024, at 12:59 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-D stated the hearing aid training and competency was not documented for all staff. She stated the test was completed and a return demonstration was performed, but there wasn't documentation available. The licensee's Personnel Records policy dated August 1, 2021, indicated employee record for each person would include documentation of orientation and competency evaluations. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current 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.	0 660		

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0 660	Continued From page 6 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included completion of a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test, for one of three employees (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee's Facility TB Risk Assessment dated June 30, 2023, indicated licensee's TB risk level was low. ULP-B was hired on May 24, 2023, to provide direct services to residents. ULP-B's employee record contained the following: -Baseline TB Screening Tool for Healthcare Workers, dated May 12, 2023, which ULP-B answered "yes," to having a positive reaction to a TB skin test; and -a chest x-ray (CXR) dated July 25, 2022, which indicated ULP-B was free of any active communicable disease like TB.	0 660		

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0 660	Continued From page 7 ULP-B's employee record lacked documentation of a positive two-step TST or Interferon-Gamma Release Assay (IGRA) test completed prior to the CXR. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) dated February 20, 2024, indicated a CXR alone was not acceptable documentation. Staff either need to provide documentation of the following: -a positive two-step TST or IGRA test along with a CXR with provider evaluation after that date; or -documentation of refusal of both the two-step TST and IGRA followed by a new CXR and provider evaluation. On February 13, 2024, at 1:41 p.m., administrator (A)-C stated they did not have documentation of a positive two-step TST or IGRA and were unaware it was required to be included in employee record. The licensee's Tuberculosis Screening/Prevention policy dated August 1, 2021, indicated the licensee would observe the recommended precautions related to TB prevention as identified by the CDC and MDH. The precautions include risk assessment, TB screening, and staff education. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire	0 790		

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0 790	Continued From page 8 extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide current tags and documentation of annual inspections of all the fire extinguishers. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a facility tour on February 12, 2024, at 1:57 p.m., with clinical nurse supervisor/licensed assisted living director (CNS/LALD)-D, survey staff observed that the fire extinguishers throughout the facility, did not have current tags or documentation to indicate that annual inspections had been performed as required.	0 790		

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0 790	Continued From page 9 Annual inspections of the fire extinguishers are required to ensure that all systems are maintained and remain in working order. During an interview on February 14, 2024, at 9:56 a.m., CNS/LALD-D verbally confirmed survey staff observations. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect some of the residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 800		

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0 800	Continued From page 10 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On February 12, 2024, at 1:57 p.m., survey staff toured the facility with clinical nurse supervisor/licensed assisted living director (CNS/LALD)-D, it was observed that one of the emergency exit doors exited out into the garage. The means of egress is required to lead and exit directly to a yard or court from occupied spaces within the facility or through a room of equal or less hazard which excludes the garage. This exit door was included on the fire safety evacuation plan. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique	0 810		

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0 810	Continued From page 11 or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 810		

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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
0 810	Continued From page 12 The findings include: On February 12, 2024, at 1:57 p.m., Clinical Nurse Supervisor/licensed assisted living director (CNS/LALD)-D provided documents via email on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not have employee actions to be taken in the event of a fire or similar emergency. The facility plan was very vague and did not provide complete actions for employees to take in the event of a fire or similar emergency as well as complete procedures for residents' movement, evacuation, and relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. During an interview on February 14, 2024, at 9:56 a.m., CNS/LALD-D verified that the fire safety and evacuation plan for the facility lacked these provisions. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (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. This MN Requirement is not met as evidenced	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39726	A. BUILDING: _____ B. WING _____	02/14/2024

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GOLDEN PATH HOME CARE SERVICES LLC	2094 151ST LANE NORTHWEST ANDOVER, MN 55304

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02310	Continued From page 13 by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards for one of one resident (R2) who utilized a hospital bed side rail. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 had diagnoses of chronic obstructive pulmonary disease (COPD), right sided hemiparesis (paralysis), traumatic brain injury, and neurogenic bladder dysfunction (unable to control bladder). R2's Service Plan (Waiver) signed November 17, 2023, indicated R2 received assistance with meals, laundry, housekeeping, medication administration, dressing and grooming, toileting, bathing, and transfers. R2's Assessment As Of Date completed on February 5, 2024, indicated R2 used side rails that were in good working condition. The assessment indicated zone 1 (within the rail) was less than 4 and ¾ inches. The assessment lacked measurements for zones 2, 3, and 4. During facility tour on February 12, 2024, at 12:10 p.m., surveyor observed two upper side rails (one	02310		

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02310	Continued From page 14 on each side of the bed) on R2's hospital bed. Both bed rails were up and secured to the bed. On February 13, 2024, at 11:24 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-D stated during her assessment, she checked to see if the side rails were loose, made sure both side rails were up while R2 was in bed, and discussed the risk and benefits of using side rails with R2. CNS/LALD-D stated she did not measure zones 1 through 4, because she was unaware of that requirement. CNS/LALD-D stated she selected zone 1 within the assessment because she thought it was the best option to choose from. CNS/LALD-D was given information on how to measure side rails. The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (within the rail) should not exceed 4 and 3/4 inches, zone 2 (under the rail, between rail supports or next to a single rail support) should not exceed 4 and 3/4 inches, zone 3 (between the rail and the mattress), should not exceed 4 and 3/4 inches, and zone 4 (under the rail, at the ends of the rail) should not exceed 2 and 3/8 inches or be greater than a 60 degree angle. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) dated February 20, 2024, indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence	02310		

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02310	Continued From page 15 needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." "Additionally, the licensee must ensure the bed rail measurements are documented and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Measurements; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. The licensee's Side Rail Use policy dated August 1, 2021, indicated the registered nurse (RN) would conduct a side rail assessment that included the following: -level of mobility, including bed mobility; -level of consciousness; -level of cognition; -presence of orthostatic hypotension; and -vision. The policy also indicated the RN was responsible	02310		

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02310	Continued From page 16 to ensure that the side rails in use are of a safe design and properly maintained. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	02310		

Minnesota Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *02/13/24*
Time: 12:00:00
Report: 8041241021

Food and Beverage Establishment Inspection Report

Location:
Golden Path Home Care Services
2094 151st Ln NW
Andover, MN55304
Anoka County, 02

Establishment Info:
ID #: N042426
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #:
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Chlorine: = 200 ppm at Degrees Fahrenheit
Location: wiping cloth bucket on counter
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 36 Degrees Fahrenheit - Location: Frigidaire cooler: milk
Violation Issued: No

Process/Item: Cold Holding
Temperature: 34 Degrees Fahrenheit - Location: Frigidair cooler: ham
Violation Issued: No

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

Inspection was completed with the Food Service Manager, Linda Mongare. Anna Bohnen was the lead Health Regulation Division Nurse Evaluator. Facility had two residents on site at time of inspection. Meals are prepared on site by staff.

This establishment has a residential kitchen. Food must be prepared for same day service only. The kitchen has wood cabinets with a hollow base, a solid surface countertop and vinyl flooring. All found to be in good condition.

Establishment has a two basin sink and a separate handwashing sink. The Frigidaire dish machine was recently tested using thermal strip and had a utensil surface temperature of at least 160F.

Discussed the following:
-Employee illness policy and logging requirements

-Handwashing
-Glove-use and bare hand contact
-Food storage and preventing cross contamination
-Date marking
-Chlorine sanitizer concentration
-Vomit clean up procedures
-Thermometer calibration
-Restrictions concerning serving a highly susceptible population

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 8041241021 of 02/13/24.

Certified Food Protection Manager: Linda Mongare

Certification Number: fm110944 Expires: 04/19/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Linda Mongare

Signed: Sarah Conboy
Sarah Conboy
Public Health San. Supervisor
651-201-3984
sarah.conboy@state.mn.us