Electronically Delivered

November 15, 2024

Licensee
Sayid Care LLC
6 Oak Ridge Drive
S St Paul, MN 55075

RE: Project Number(s) SL40090015

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 October 15, 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.

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

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. 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.

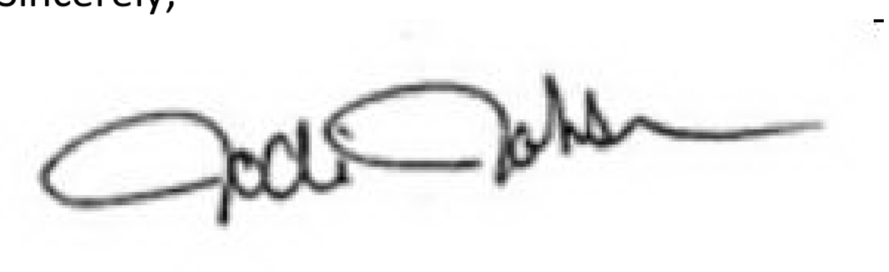
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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.

If you have any questions, please contact me.

Sincerely,



Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40090	A. BUILDING: _____ B. WING _____	10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAYID CARE LLC	6 OAK RIDGE DRIVE S ST PAUL, MN 55075

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0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL40090015 On October 14, 2024, through October 15, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were zero resident(s); zero receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of	0 650		

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0 650	Continued From page 1 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 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 the employee record contained the required content for one of one employee (unlicensed personal (ULP)-D). 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).	0 650		

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0 650	Continued From page 2 The findings include: ULP-D was hired on July 6, 2023, to provider direct care services to the residents at the assisted living facility. ULP-D's employee file contained an orientation checklist dated July 27, 2023, which included a check-off spot for a signed job description; however, it was left blank. ULP-D's file failed to show evidence of a current job description. On October 15, 2024, at 11:32 a.m. licensed assisted living director (LALD)-C stated they do not have a job description on file for ULP-D. LALD-C stated they were aware of the process, but the staff before her must have forgotten to provide it. The licensee's Personnel Records policy July 18, 2023, indicated at a minimum all documents related to the following are kept in the personnel record: Signed job description. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control	0 660		

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0 660	Continued From page 3 program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a TB (tuberculosis) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) guidelines and the Minnesota Department of Health (MDH). The licensee failed to ensure two of two employees, (registered nurse (RN)-B, and unlicensed personnel (ULP)-D) were screened for active TB and retained documentation in the employee files. 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:	0 660		

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0 660	Continued From page 4 RN-B RN-B was hired on July 6, 2023, to provide nursing oversight in the assisted living facility. RN-B's employee file contained documentation of a TB blood test dated June 14, 2023, which was negative. The file also contained TB training completed on July 27, 2023. On October 15, 2024, at 10:30 a.m., licensed assisted living director (LALD)-C handed the surveyor a TB screening for RN-B that was back dated to July 25, 2023. LALD-C stated "I know we completed one when she started and could not find it in her file, so we completed it and signed it yesterday" (October 14, 2024). ULP-D ULP-D was hired on July 6, 2023, to provide direct care services to residents at the assisted living facility. ULP-D's employee file contained documentation of a TB blood test dated June 19, 2023, which was negative. The file also contained TB training completed on July 27, 2023. ULP-D's file lacked evidence that TB baseline screening was completed. On October 15, 2024, at 11:32 a.m., LALD-C stated they did not have a TB screening for ULP-D. The licensee's Tuberculosis Screening/Prevention policy dated July 18,2023, indicated baseline testing is completed on hire for all direct care providers and anyone who visits residents (including volunteers). The employees	0 660		

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0 660	Continued From page 5 receive baseline TB screening upon hire to test for infection. The MDH guidelines, "Regulations for Tuberculosis Control in Minnesota Health Care Settings" dated July 2013, and based on CDC guidelines, indicated all health care settings in Minnesota should perform an initial facility TB risk assessment. A TB infection control program should include the following: written TB infection control procedures. HCW's education should focus on basic information about your health care setting's infection control plan (i.e., how to implement your early recognition, isolation, and referral procedure), especially any sections that employees are responsible for implementing. The guidelines also indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies	0 680		

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0 680	Continued From page 6 temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	0 680		

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0 680	Continued From page 7 The licensee's EP manual, last updated on March 3, 2024, included a hazard vulnerability assessment and training and drills. The EP manual failed to include the following: Subsistence needs for staff and patients. Procedures for tracking of staff and patients Policies and Procedures including evacuation. Policies and procedures for sheltering Policies and procedures for medical documents. Policies and procedures for volunteers. Arrangement with other facilities. Emergency officials contact information. Methods for sharing information. Emergency prep testing requirements. On October 14, 2024, at 11:00 a.m., licensed assisted living director (LALD)-C and housing manager (HM)-A stated they do not have any coalition training and was not aware of the requirement. The licensee's Emergency Preparedness policy dated July 18, 2023, indicated the licensee references Centers for Medicare and Medicaid (CMS) Stated operations manual Appendix Z. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:	0 780		

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0 780	Continued From page 8 (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide interconnected smoke alarms throughout the facility. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include:	0 780		

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0 780	Continued From page 9 On a facility tour with licensed assisted living director (LALD)-C, on October 15, 2024, from 9:50 a.m. to 11:50 a.m., it was observed that smoke alarms were not interconnected so activation of one alarm activates all alarms. Upon testing, the smoke alarms in the following locations did not sound when the test button was pressed: 1. Bedroom A, upstairs, battery smoke alarm was not interconnected. 2. Bedroom B, upstairs, battery smoke alarm was not interconnected. 3. Bedroom C, upstairs, battery smoke alarm was not interconnected. 4. Bedroom D, upstairs, battery smoke alarm was not interconnected. 5. Bedroom E, (Handicap room) main level, no smoke alarm installed. 6. Bedroom F, basement, battery smoke alarm was not interconnected. All dwelling units required to have multiple smoke alarms are required to have interconnected alarms so activation of one alarm activates all alarms within the dwelling unit. These deficient conditions were visually verified by LALD-C accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and	0 810		

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0 810	Continued From page 10 maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (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 observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all	0 810		

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0 810	Continued From page 11 residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On a facility tour with licensed assisted living director (LALD)-C, on October 15, 2024, from 9:50 a.m. to 11:50 a.m., the surveyor observed the fire safety and evacuation plan was not located in a central location for all staff and occupants' accessibility and did not include room identifiers. On October 15, 2024, licensed assisted living director (LALD)-C provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "Fire Policy", dated 2022, failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The provided FSEP was from a third-party provider and had not been updated to the specific facility. The plan included the acronym R.A.C.E. (Rescue, Alarm,	0 810		

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0 810	Continued From page 12 Confine, and Extinguish or Evacuate) but the plan was designed for a building with life safety systems such as fire doors and smoke compartments. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. On October 15, 2024, at 11:30 a.m., LALD-C stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. The policy reviewed was an unedited policy purchased from a third-party provider that was not specific to the facility. TRAINING: The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. The provided records were for fire safety training offered by third-party online software that could not be modified to include the facility-specific fire safety plans. LALD-C was unable to provide documentation showing any training offered or training scheduled for a future date for employees on the fire safety and	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40090	A. BUILDING: _____ B. WING _____	10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAYID CARE LLC	6 OAK RIDGE DRIVE S ST PAUL, MN 55075

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0 810	Continued From page 13 evacuation plan. On October 15, 2024, at 11:30 a.m., LALD-C stated they understood the requirements for training residents and staff and would implement a training program that was compliant with statute requirements. DRILLS: The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Licensee lacked any documentation of drills since obtaining license. No other documentation was provided. On October 15, 2024, at 11:30 a.m., LALD-C stated they only had one resident for a few days and didn't know drills were still to be required to be conducted by staff. Education was given, that drills are still required for staff in accordance with statue requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01530 SS=E	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40090	A. BUILDING: _____ B. WING _____	10/15/2024

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01530	Continued From page 14 employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of two employees (registered nurse (RN)-B and unlicensed personnel (ULP)-D) received the required amount of dementia care training in the required time frame. 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). The findings include:	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01530	Continued From page 15 RN-B RN-B was hired on July 6, 2023, to provide nursing oversight in the assisted living facility. RN-B's employee record did not contain documentation that RN-B completed all the required eight hours of dementia training within 160 hours of the start date. RN-B's record contained an orientation checklist completed on July 27, 2023, with many orientation topics marked as completed on July 27, 2023; however, dementia training was left blank. RN-B's record included documentation of on-line training topics that had been completed. RN-B completed 5.25 hours of Dementia training on April 6, 2024, and April 8, 2024. (275 days after the hire date). ULP-D ULP-D was hired on July 6, 2023, to provide direct care services to the licensee's residents. ULP-D's employee records did not contain documentation that ULP-D completed all the required eight hours of dementia training within 160 hours of the start date. ULP-D's employee records contained an orientation checklist completed on July 27, 2023, with many orientation topics marked off; however, dementia training was left blank. On October 14, 2024, at 12:08 p.m. licensed assisted living director (LALD)-C stated the employee records lacked eight hours of initial dementia training. LALD-C stated all staff should	01530		

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01530	Continued From page 16 have eight hours of training, and she would look to see if there was record of any more training. The licensee's Dementia Education policy dated July 18, 2023, indicated direct-care employees must have completed at least eight hours of initial training on dementia care. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		

DEPARTMENT OF HEALTH

Type: Full
Date: *10/15/24*
Time: 11:49:53
Report: 1036241219

Food and Beverage Establishment Inspection Report

Location:
SAYID CARE LLC
6 OAK RIDGE DRIVE
South St Paul, MN55075
Dakota County, 19

Establishment Info:
ID #: 0043712
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/24

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

UTENSIL SURFACE TEMP: = at 150 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Ambient Temp
Temperature: 39 Degrees Fahrenheit - Location: SAMSUNG FRIDGE
Violation Issued: No

Process/Item: Ambient Temp
Temperature: -11 Degrees Fahrenheit - Location: SAMSUNG FREEZER
Violation Issued: No

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

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. SURVEYOR FROM HRD WAS TRACEY FEARON. INSPECTION CONDUCTED IN PRESENCE OF MUSTAFA IBRAHIM, THE PERSON IN CHARGE. AT TIME OF INSPECTION,
ESTABLISHMENT HAD NO RESIDENTS. ALL VIOLATIONS WERE DISCUSSED WITH THE SURVEYOR AND PERSON IN CHARGE DURING INSPECTION.

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

FOOD SERVICE AREA FLOORS, WALLS, CEILINGS, COUNTERTOPS, AND FINISH MATERIALS MUST BE NON-ABSORBANT, SMOOTH, DURABLE, AND EASILY CLEANABLE. CEILINGS

CANNOT HAVE POPCORN TEXTURE. CABINETS CANNOT HAVE HOLLOW BASES. EXPOSED WOOD IS NOT APPROVED FOR FOOD SERVICE AREAS. WOOD IS NOT AN APPROVED FOOD CONTACT SURFACE.

ADDITIONAL TOPICS DISCUSSED WITH THE PERSON IN CHARGE:
- EMPLOYEE ILLNESS LOG AND EXCLUSION POLICY.
- HAND WASHING POLICY AND REVIEW.
- GLOVE USAGE.
- NO BHC WITH RTE FOODS.
- THERMOMETER USE AND CALIBRATION.
- DATE MARKING TCS FOODS.
- PEST CONTROL.
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS.
- ANSI 184 STANDARD FOR RESIDENTIAL DISH WASHER.

**IF ANY RESIDENT COMPLAINS OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE CUSTOMER. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.

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

I acknowledge receipt of the inspection report number 1036241219 of 10/15/24.

Certified Food Protection Manager: MUSTAFA M. IBRAHIM

Certification Number: FM123069 Expires: 05/18/27

Inspection report reviewed with person in charge and emailed.

Signed: _____
MUSTAFA IBRAHIM
PERSON IN CHARGE

Signed: _____
Jeff Johanson