Electronically Delivered

May 24, 2024

Licensee
Richfield Senior Suites LLC
6808 3rd Avenue South
Richfield, MN 55423

RE: Project Number(s) SL30323015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 23, 2024, 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 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.31, Subd. 4(a)(5), MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. MDH may impose a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. MDH also may impose a

fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

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

St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. 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

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

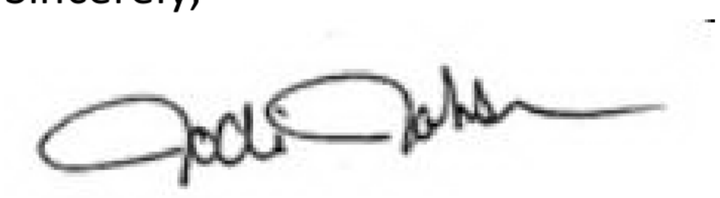
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms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



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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30323	A. BUILDING: _____ B. WING _____	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD SENIOR SUITES LLC	6808 3RD AVENUE SOUTH RICHFIELD, MN 55423

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******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: SL30323015-0 On April 22, 2024, through April 23, 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 resident(s); two receiving services under the provider's Assisted Living license. 2310: The immediacy has been removed on April 23, 2024; however, non-compliance remains at a Level 3/Widespread (l).	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.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a staffing plan to determine staffing levels to meet the needs of all residents as required. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 470		

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0 470	Continued From page 2 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee held an Assisted Living license. The facility was licensed for a capacity of five residents and had a current census of two residents. During the entrance conference on April 22, 2024, at 10:00 a.m. with housing manager (HM)-A and licensed practical nurse (LPN)-B, the staffing schedule included: - the Registered Nurse (RN) was on call 24/7; - the LPN worked Monday - Thursday, and when needed; and - the shifts were staffed with one to two unlicensed personnel (ULP) from 6:00 a.m. to 6:00 p.m., and 6 p.m. to 6 a.m. (12 hour shifts) On April 23, 2024, at 11:04 a.m. HM-A stated he was unaware of needing a staffing plan, but did have the staff schedule posted. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according	0 480		

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0 480	Continued From page 3 to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated April 23, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that	0 580		

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0 580	Continued From page 4 have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in and maintain documentation of quality management activity appropriate to the size and relevant to the type of services provided by the assisted living. This had the potential to affect all residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on April 22, 2024, at 10:00 a.m. with housing manager (HM)-A and licensed assisted living director (LALD)-B, both stated they were unaware of the requirement of a quality management program. The licensee's Quality Improvement policy dated August 28, 2023, indicated the licensee has established a quality improvement program and to systematically monitor and evaluate the quality,	0 580		

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0 580	Continued From page 5 safety, and appropriateness of resident care. To identify, take action and re-evaluate problems identified within the organization. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement an individual abuse prevention plan (IAPP) that included an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults and the person's risk of abusing other vulnerable adults for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 630		

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0 630	Continued From page 6 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: R2 started receiving services from the licensee on February 27, 2023, with a diagnoses of depression. R2's service plan dated February 27, 2023, included medication management and assistance with activities of daily living (ADL). On April 23, 2024, at 8:30 a.m. housing manager (HM)-A was observed administering R2's morning medication. On April 23, 2024, at 1:30 p.m. licensed assisted living director (LALD)-B reviewed R2's file and confirmed an IAPP was missing from the file. LALD-B stated he was fairly new in his position and was not sure why R2's record did not have one. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 650 SS=D	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	0 650		

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0 650	Continued From page 7 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 observation, interview, and record review, the licensee failed to ensure the employee record contained the required content for one of one employee records (housing manager (HM)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include:	0 650		

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0 650	Continued From page 8 HM-A was hired on August 1, 2017, as the housing manager and to provide direct care to residents. On April 22, 2024, from 11:30 p.m. to 12:30 p.m. HM-A was observed assisting R2 with toileting and then administering R1's morning medications. HM-A's employee record included a performance evaluation completed July 2021, and a transcript with training completed August 2023-September 2023. HM-A's employee record also contained evidence of Tuberculosis (TB) testing and screening completed at hire. HM-A's employee record lacked evidence of the following items: - Annual performance evaluation after 2021; - Documentation of infection control training; and - Documentation of TB training On April 23, 2024, at 8:10 a.m. licensed assisted living director (LALD)-B and HM-A stated HM-A's employee record did not contain a current annual performance evaluation or evidence of TB and infection control training. HM-A stated it might be misplaced because he was positive he completed it. The licensee's Personnel Records policy dated August 28, 2023, indicated employee records will include all documents related to: -Records of annual training and infection control training -Documentation of annual performance reviews identifying areas of improvement needed and training needs.	0 650		

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0 650	Continued From page 9 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (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 develop a written emergency preparedness plan with all the required content	0 680		

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0 680	Continued From page 10 as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's Emergency Preparedness manual consisted of a multiple page template with blank fields for individual information to be added. The licensee lacked evidence of a completed hazard vulnerability assessment (HVA). On April 23, 2024, at 8:30 a.m. housing manager (HM)-A stated the HVA was blank, and he has not reviewed it. The licensee's Emergency Preparedness policy dated August 28, 2023, referenced Centers for Medicare and Medicaid (CMS) State Operations Manual Appendix Z and indicated they follow Minnesota (MN) Rules 4659.0100. No further information 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	0 780		

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0 780	Continued From page 11 the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that are interconnected so that actuation of one alarm causes all alarms in the dwelling unit to actuate. 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	0 780		

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	30323	A. BUILDING: _____ B. WING _____	04/23/2024

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0 780	Continued From page 12 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 April 22, 2024, at 11:00 a.m., survey staff toured the facility with housing manager (HM)-A. During the tour, it was observed upon testing, the smoke alarms in the facility were not interconnected, so the actuation of one smoke alarm would cause all other alarms in the facility to actuate. On April 22, 2024, at 11:20 a.m., HM-A confirmed the licensee installed smoke alarms in the resident's sleeping rooms and the immediate vicinity of sleeping rooms, but the smoke alarms were not interconnected to each other. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire 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	0 790		

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0 790	Continued From page 13 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to perform the required monthly maintenance on fire extinguishers. This had the potential to affect all current 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 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 April 22, 2024, at 11:00 a.m., survey staff toured the facility with housing manager (HM)-A. During the facility tour, it was observed the portable fire extinguishers were tagged, showing the required annual service but lacked records to show the required monthly visual inspections were performed or recorded for all portable fire extinguishers throughout buildings. It was also observed that the fire extinguisher was stored on top of the refrigerator. Survey staff explained to HM-A that the fire extinguisher should be mounted with their carrying handles no higher than 5 feet from the floor. On April 22, 2024, at 11:20 a.m., HM-A verified that the required maintenance had not been completed and stated he would mount the fire extinguisher at the appropriate height.	0 790		

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0 790	Continued From page 14 TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=D	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: The licensee failed to maintain the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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 April 22, 2024, at 11:00 a.m., survey staff toured the facility with housing manager (HM)-A. During the facility tour, survey staff observed the following items:	0 800		

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0 800	Continued From page 15 It was observed unoccupied bedroom #6 on the lower level did not have windows that met the minimum size requirements for egress escape. It was also observed there were brown stains on the acoustic ceiling tile with evidence of water leakage from above the ceiling. During the interview on April 22, 2024, at 11:20 a.m., HM-A stated the bedroom #6 was not used as resident sleeping room and confirmed the room was mislabeled in the posted evacuation plan. During the same interview, HM-A verified that he needed to look into the water leakage and repair the stained ceiling. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) 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	0 810		

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0 810	Continued From page 16 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 the interview and record review, the licensee failed to develop the fire safety and evacuation plan with the required content, failed to provide the required training, and failed to provide the required drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 April 23, 2024, at 10:00 am., housing manager (HM)-A provided documentation on the	0 810		

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0 810	Continued From page 17 fire safety and evacuation plan (FSEP), fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The FSEP and the posted evacuation plans did not show the location and number of resident rooms. 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 FSEP was a third-party consultant provided plan, and it was not updated to meet the facility-specific layout. The FSEP included the RACE (Remove, Alarm, Confine, and Extinguish or Evacuate) acronym as the fire safety procedure and instructed staff to pull the nearest fire alarm in case of fire, but the facility did not have a fire alarm system. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan. The FSEP 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 failed to include ways to move, evacuate residents based on the facility's specific layout in the event of a fire or similar emergency. During the interview on April 23, 2024, at 10:30 am., HM-A stated the fire safety and evacuation plan was from a third-party provider and verified the facility needed to update the fire safety and	0 810		

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0 810	Continued From page 18 evacuation plan, including the facility-specific fire safety protocols. TRAINING Record review of the available documentation indicated employees did not receive training twice per year after initial hire. During the interview on April 23, 2024, at 10:30 am., HM-A stated the licensee provided annual training on the fire safety and evacuation plan to employees, but not twice per year after the initial hire, as required by statute. HM-A confirmed that there was no further documented training for the staff on the fire safety and evacuation plan as required by statute. DRILLS Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month as required by statute. Provided documentation indicated that the drills were conducted on 2/12/24 at 2 p.m., 9/27/23 at 9 a.m., and 9/28/23 at 4 p.m., with no further drills being documented. During the interview on April 23, 2024, at 10:30 a.m., HM-A verified there were no further documented drills for the facility and verified this deficient condition. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an	0 950		

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0 950	Continued From page 19 assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the required notice for the right to a designated representative with the required verbiage was on a document separate from the contract for one of one resident (R2). This practice resulted in a level one violation (a violation that has no potential to cause more than	0 950		

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0 950	Continued From page 20 a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: R2's Resident Contract for Assisted Living dated February 27, 2023, lacked the required notice to designate a representative. R2's record lacked evidence in writing of providing on a document separate from the contact verbatim notice of "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." On April 22, 2024, at 1:30 p.m. housing director (HD)-A and licensed assisted living director (LALD)-B stated R2's file did not contain the correct language and was unaware of the requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		

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01700	Continued From page 21	01700		
01700 SS=F	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management assessment to include all required content for one of one resident (R2) prior to providing medication management	01700		

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01700	Continued From page 22 services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death),) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: During the entrance conference on April 22, 2024, at 10:00 a.m. with housing manager (HM)-A and licensed assisted living director (LALD)-B, they stated the licensee provided medication management services to the residents of the facility. R2 began receiving services on February 27, 2023, with a diagnosis of depression and diabetes. On April 23, 2024, at 8:30 a.m. HM-A was observed to administer morning medications to R2. R2's care plan dated February 28, 2023, indicated she received medication administration. R2's April 2024, Medication administration Record indicated R2 took the following medications: Amlodipine (used for lowering blood pressure), Glipizide (lowers blood sugar), Lisinopril (treats high blood pressure), Refresh tears (for dry eyes), and Byetta (lowers blood sugar levels). R2's record lacked evidence the licensee	01700		

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01700	Continued From page 23 conducted a face-to-face review of all medications R2 was known to be taking to include indications of use, side effects, contraindications, interventions to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. On April 23, 2024, at 11:07 a.m. LALD-A reviewed R2's file and stated he was not aware of the medication assessment requirements. The licensee's Assessment and Reassessment policy dated August 28, 2023, indicated the registered nurse (RN) will provide the admission visit, and conduct a comprehensive assessment. There was no information specific to a medication assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following:	01730		

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01730	Continued From page 24 (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop an individualized medication management plan with the required content for one of one resident (R2). This practice resulted in a level two violation (a	01730		

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01730	Continued From page 25 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include. During the entrance conference on April 22, 2024, at 10:00 a.m. with housing manager (HM)-A and licensed assisted living director (LALD)-B, they stated the licensee provided medication management services to the residents of the facility. R2 began receiving services on February 27, 2023, with a diagnosis of depression and diabetes. On April 23, 2024, at 8:30 a.m. HM-A was observed administering morning medications to R2. R2's care plan dated February 28, 2023, indicated she received medication administration. R2's April 2024, Medication administration Record indicated R2 took the following medications: Amlodipine (used for lowering blood pressure), Glipizide (lowers blood sugar), Lisinopril (treats high blood pressure), Refresh tears (for dry eyes), and Byetta (lowers blood sugar levels). R2's file failed to show evidence of a completed medication plan with all the following required information: - a description of storage of medications based	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30323	A. BUILDING: _____ B. WING _____	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD SENIOR SUITES LLC	6808 3RD AVENUE SOUTH RICHFIELD, MN 55423

(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
01730	Continued From page 26 on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; - procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and - any resident-specific requirements relating to documentation medication administration, verifications that all medications are administer as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. On April 23, 2024, at 11:07 a.m. LALD-A reviewed R2's file and stated he was not aware of the medication management plan requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
02310 SS=I	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 by: Based on observation, interview, and record review, the licensee failed to ensure care and	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30323	A. BUILDING: _____ B. WING _____	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD SENIOR SUITES LLC	6808 3RD AVENUE SOUTH RICHFIELD, MN 55423

(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
02310	Continued From page 27 services were provided according to acceptable health care and medical or nursing standards for the licensee's one resident (R2) with side rails. This resulted in an immediate correction order on April 23, 2024. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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 began receiving services on February 27, 2023, with a diagnosis of depression and diabetes. On April 22, 2024, at 11:00 a.m. during the facility tour with the engineer. R2 was observed to have a hospital bed with upper side rails on both sides in the down position. R2's care plan dated February 28, 2023, indicated she received services to include medication administration, bathing/dressing/grooming assistance, and assist of one for transfers. R2's nurse assessment dated February, 29, 2024, did not indicate a side rail or hospital bed was used. R2's record lacked evidence of a completed side rail assessment with measurements, lacked indication if the side rails were Food and Drug	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30323	A. BUILDING: _____ B. WING _____	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD SENIOR SUITES LLC	6808 3RD AVENUE SOUTH RICHFIELD, MN 55423

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02310	Continued From page 28 Administration (FDA) compliant, and lacked notation risk verses benefits were discussed with the resident or responsible party. On April 23, 2024, at 10:30 a.m. the surveyor and licensed assisted living director (LALD)-B reviewed R2's hospital bed and noted upper side rails on both sides were in the down position. When asked about the assessment, LALD-B stated they "misplaced the side rail assessment" for R2. On April 23, 2024, at 12:15 p.m. housing manager (HM)-A stated R2 used the side rail at night to move themselves from side to side while in bed. The Food and Drug Administration's (FDA), A Guide to Bed Safety, revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." On page 21, Table 3 Summary of FDA Hospital Bed Dimensional Limit Recommendations indicated specific measurement limits for each entrapment zone. The licensee's Side Rail Use policy dated August 28, 2023, indicated before implementing side rails for a resident, the RN will conduct a side rail	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30323	A. BUILDING: _____ B. WING _____	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD SENIOR SUITES LLC	6808 3RD AVENUE SOUTH RICHFIELD, MN 55423

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02310	Continued From page 29 assessment that includes the following: level of mobility, ability to transfer in and out of bed, vision, level of consciousness, level of cognition, physical help. The results of the side rail assessment will be documented in the clinical record. The Minnesota Department of Health's (MDH) Assisted Living: Resources and Frequently-Asked Questions (FAQs) website accessed on March 20, 2023, at 9:33 a.m., read under Hospital-style bed rails licensees should ensure, "measurements were completed and documented, the rails were FDA compliant, and the risk versus benefits were discussed and documented with the resident/responsible party." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate The immediacy was lifted on April 23, 2024, based on supervisor review; however, non-compliance remains at a level 3/Widespread (I).	02310		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by:	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30323	A. BUILDING: _____ B. WING _____	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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03090	Continued From page 30 Based on observation, interview, and record review, the licensee failed to ensure signage was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all residents, staff, and visitors of the licensee. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: On April 22, 2024, at 11:00 a.m. during the entrance tour, the surveyor noted the licensee failed to post an electronic messaging sign at the entrance. On April 22, 2024, at 12:00 p.m. housing manager (HM)-A stated they do not have a posted sign for electronic monitoring and was not aware they needed one if they were not providing electronic monitoring. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090		

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

Type: Full
Date: *04/23/24*
Time: 10:30:00
Report: 1005241100

Food and Beverage Establishment Inspection Report

Location:
Richfield Senior Suites Llc
6808 3rd Avenue South
Richfield, MN55423
Hennepin County, 27

Establishment Info:
ID #: 0038581
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6128663961
ID #:

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

The following orders were issued during this inspection.

2-200 Employee Health

2-201.11C ***** Priority 1 *****

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.

NO EMPLOYEE ILLNESS LOG ON SITE. DISCUSSED REQUIREMENTS FOR DOCUMENTING AND EXCLUDING EMPLOYEES ILL WITH VOMITING OR DIARRHEA. BLANK ILLNESS LOG LEFT ON SITE.

Comply By: 04/23/24

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

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

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

AN OPENED PACKAGE OF GROUND BEEF WAS STORED NEXT TO OPENED PACKAGES OF DELI MEATS. DISCUSSED PROPER STORAGE TO PREVENT CROSS-CONTAMINATION WITH RAW ANIMAL FOODS. FACILITY WILL DESIGNATE ONE OF THE FRIDGE DRAWERS FOR STORAGE OF RAW ANIMAL FOODS.

Comply By: 04/23/24

3-500C Microbial Control: date marking

3-501.17B ***** Priority 2 *****

MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The

date must not exceed the manufacturer's use-by-date.

OPENED PACKAGES OF FOOD, INCLUDING MILK AND DELI MEATS, WERE NOT DATE MARKED. DISCUSSED PROPER DATE MARKING AND DISPOSITION, AND LEFT FACT SHEET ON SITE.

Comply By: 04/23/24

4-300 Equipment Numbers and Capacities

4-302.12B ***** Priority 2 *****

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

THERE IS NO FOOD THERMOMETER ON SITE. PROVIDE A THERMOMETER TO PROPERLY MONITOR COLD HOLDING AND COOKING TEMPERATURES.

Comply By: 04/30/24

4-200 Equipment Design and Construction

4-204.112A

MN Rule 4626.0620A Provide a temperature measuring device located in the warmest part of mechanically refrigerated units and coolest part of hot food storage units that are capable of measuring air temperature or a simulated product temperature.

NO AMBIENT THERMOMETER WAS AVAILABLE IN THE REFRIGERATOR. CORRECTED ON SITE.

Comply By: 04/23/24

6-300 Physical Facility Numbers and Capacities

6-301.14A

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

NO SIGN WAS POSTED AT THE HANDWASHING SINK. SIGN LEFT ON SITE.

Comply By: 04/23/24

Food and Equipment Temperatures

Process/Item: Cold Hold/HAM
Temperature: 34 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR
Violation Issued: No

Process/Item: Cold Hold/TURKEY
Temperature: 35 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR
Violation Issued: No

Process/Item: Cold Hold/MILK
Temperature: 40 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR
Violation Issued: No

Type: Full
Date: *04/23/24*
Time: 10:30:00
Report: 1005241100
Richfield Senior Suites Llc

Food and Beverage Establishment Inspection Report

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

INSPECTION COMPLETED WITH HOUSE MANAGER AND REVIEWED WITH HRD NURSE EVALUATOR TRACEY FEARON.

DISCUSSED DATE MARKING, GLOVE USE, COOKING TEMPERATURES, CROSS-CONTAMINATION, AND EMPLOYEE ILLNESS.

A MAXIMUM REGISTERING TEMPERATURE INDICATOR WAS ON SITE AND DIRECTOR SAYS THE TEMPERATURE IS AROUND 163 DEGREES F WHEN THEY RUN IT THROUGH THE DISHWASHER. DISCUSSED THAT THE MINIMUM REQUIRED UTENSIL SURFACE TEMPERATURE FOR THE DISHWASHER IS 160 DEGREES F.

KITCHEN IS RESIDENTIAL AND FOOD IS PREPARED FOR SAME DAY SERVICE.

FLOORING IS LAMINATE, CABINETS ARE WOOD WITH HOLLOW BASE, AND COUNTERS ARE LAMINATE. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

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 1005241100 of 04/23/24.

Certified Food Protection Manager OBSITU S. BEYAN

Certification Number: FM119042 Expires: 05/29/26

Inspection report reviewed with person in charge and emailed.

Signed: _____

NEGASSA DEGAGA
HOUSE MANAGER

Signed: _____

Jessica Davis
Public Health Sanitarian III
651-201-3961
jessica.davis@state.mn.us