



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

March 8, 2023

Licensee
Solution Home Care LLC
9037 Moorland Chase
Brooklyn Center, MN 55443

RE: Project Number(s) SL36791015

Dear Licensee:

On December 2, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on September 9, 2023. This follow-up evaluation determined your facility had not corrected all of the state licensing orders issued pursuant to the September 9, 2023 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on September 9, 2023, found not corrected at the time of the December 2, 2022, follow-up evaluation and/or subject to penalty assessment are as follows:

0800-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (4) - \$500.00

0810-Fire Protection And Physical Environment-144g.45 Subd. 2 (b)-(f) - \$500.00

The details of the violations noted at the time of this follow-up evaluation completed on December 2, 2022 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order by the correction order date. The commissioner may request a copy of this documentation and the assisted living facility's action to respond to the correction orders in future evaluations, upon a complaint investigation, and as otherwise needed.

IMPOSITION OF FINES:

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.

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.

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

REQUESTING A HEARING

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

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.

We urge you to review these orders carefully. If you have questions, please contact Jonathan Hill at 651-201-3993.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Sincerely,

A handwritten signature in black ink, appearing to read "Jonathan Hill", written in a cursive style.

Jonathan Hill, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jonathan.hill@state.mn.us
Telephone: 651-201-3993 Fax: 651-215-9697

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36791	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 12/02/2022
NAME OF PROVIDER OR SUPPLIER SOLUTION HOME CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 9037 MOORLAND CHASE BROOKLYN CENTER, MN 55443		
(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 On December 2, 2022, the Minnesota Department of Health initiated a licensing order follow-up related to correction orders issued for survey #SL36791015-1. The following correction orders are re-issued for tag identification 0800 and 0810.	{0 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	{0 480}		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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{0 480}	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: No further action required	{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 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: No further action required	{0 580}			
{0 640} SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by	{0 640}			

Minnesota Department of Health

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{0 640}	Continued From page 2 the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: No further action required	{0 640}		
{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	{0 680}		

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{0 680}	Continued From page 3 requirements adopted in rule. This MN Requirement is not met as evidenced by: No further action required	{0 680}		
{0 730} SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the	{0 730}		

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{0 730}	Continued From page 4 needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: No further action required	{0 730}			
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the	{0 800}			

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{0 800}	Continued From page 5 potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: On December 2, 2022, at 11:36 a.m., survey staff requested documentation of corrections in an email sent to the housing manager (HM)-A. The HM-A responded on December 5, 2022, with photos and descriptions of the corrections that had been completed since September 7, 2022. Documentation of corrections for the following items was not provided: 1. The crank mechanism was not working properly for the egress window in bedroom 3, which made opening the window difficult. 2. There were deck boards and railings with exposed nails and screws in the backyard. 3. The sweep on the back storm door was loose which prevented this door from operating correctly. 4. There was a crack in the ceiling running the entire length of the living room and the finish was starting to peel in this area. 5. One side of the bi-fold door in the laundry room was broken. On December 7, 2022, at 2:27 p.m., survey staff contacted HM-A by phone. The HM-A explained that the landlord had been contacted multiple times but had not completed the repairs as requested by the HM-A.	{0 800}		

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{0 800}	Continued From page 6 No further information was provided.	{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 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.	{0 810}		

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{0 810}	Continued From page 7 This MN Requirement is not met as evidenced by: Based on a record review, the licensee failed to develop a fire safety and evacuation plan with the required elements, failed to provide required employee and resident training on fire safety and evacuation, and failed to conduct required evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: On December 2, 2022, at 11:36 a.m. and 11:39 a.m., survey staff requested documentation of corrections in two emails sent to the housing manager (HM)-A. The HM-A responded on December 9, 2022, with a Solution Home Care Emergency Preparedness Manual for review. On December 23, 2022, between 10:30 a.m. and 11:30 a.m., survey staff reviewed the Fire Safety Policy dated August 1, 2021. Record review of the available documentation indicated that the licensee had not developed fire safety and evacuation plans for the facility location. 1. The location and number of resident sleeping rooms were not identified. 2. Limited employee actions to be taken in the	{0 810}		

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{0 810}	Continued From page 8 event of a fire or similar emergency were included in the plan. The plan instructed employees to call 911, retrieve fire extinguishers and use the RACE acronym but did not provide complete actions for employees to take in the event of a fire or similar emergency. 3. The plan had vague fire protection procedures for residents. The plan instructions were to evacuate endangered occupants from the building and assist residents to stoop or crawl to avoid smoke but did not include fire protection procedures necessary for residents. 4. The plan did not include 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. Record review of available documentation indicated that the licensee did not provide employee training on the fire safety and evacuation plans upon hire and at least twice per year thereafter. The fire policy had the correct training frequency, but no training logs or schedules were included. Documentation was requested by survey staff but not provided to support that the required employee training frequency had been met. Record review of the available documentation indicated that the licensee did not provide annual training to residents who can assist in their own evacuation on the proper actions to take in the event of a fire to include movement, evacuation, or relocation as required by statute. The fire policy had the correct training frequency, but documentation was not provided to support that annual resident training had been completed. Record review of the available documentation	{0 810}			

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{0 810}	Continued From page 9 indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month as required by statute. The fire policy had the correct evacuation drill frequency, but no completed evacuation drill logs or schedules were included. No further information was provided.	{0 810}		
{01910} SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: No further action required	{01910}		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

September 27, 2022

Administrator
Solution Home Care LLC
9037 Moorland Chase
Brooklyn Center, MN 55443

RE: Project Number(s) SL36791015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on September 9, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health 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.

The enclosed State Form documents the state licensing orders. The Department of Health 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 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.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes 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. The Department of Health 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 (a)(5)(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, no immediate fines are assessed.

DOCUMENTATION OF ACTION TO COMPLY

Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction 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 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.

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Please address your cover letter for general reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Solution Home Care LLC

September 27, 2022

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You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

A handwritten signature in dark ink, appearing to read "Jonathan Hill", is positioned above the typed name.

Jonathan Hill, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
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HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36791	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/09/2022
NAME OF PROVIDER OR SUPPLIER SOLUTION HOME CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 9037 MOORLAND CHASE BROOKLYN CENTER, MN 55443		
(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 Initial comments *****ATTENTION***** ASSISTED LIVING 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: SL36791015 On September 06, 22, 2022 through September 07, 2022 the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were no residents receiving services under the provider's Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing 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.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according 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 included document titled, Food and Beverage Establishment Inspection Report dated September 07, 2022, for the specific	0 480		

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0 480	Continued From page 2 Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	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 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 activities, this had the potential to all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 580		

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0 580	Continued From page 3 The findings include: On September 07, 2022, at 11:00 a.m., the surveyor requested the licensee's documentation of any quality management activities. On September 07, 2022, at 12:00 p.m. house manager (HM)- B confirmed the license had no current documentation of quality management activity. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to support protection and safety by not posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting	0 640		

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0 640	Continued From page 4 Center (MAARC) and failed to post the 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to affect 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: The licensee lacked the following: On September 06, 2022, at 11:00 a.m., during observation, the facility's main entry area and common areas lacked the required posted information. - posting of 911 emergency number in common areas and near telephones provided by the Assisted Living facility - posting of information and the reporting number for the MAARC to report suspected maltreatment of a vulnerable adult under section 626.557 On September 06, 2022, at 11:30 a.m., a registered nurse (RN)-A and house manager (HM)-B confirmed the required content noted above had not been posted. No further information was provided.	0 640		

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0 640	Continued From page 5	0 640		
	TIME PERIOD FOR CORRECTION: Seven (7) days			
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 tenant 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 observation, interview and record review, the licensee failed to have a written emergency preparedness plan with all the	0 680		

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0 680	Continued From page 6 required content and failed to post an emergency preparedness plan prominently. This had the potential to affect all staff, visitors, and residents receiving services under the license. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 06, 2022, at 11:00 a.m., during the entrance conference, the surveyor requested to review the licensee's emergency preparedness plan. During a facility tour on September 06, 2022, at 11:30 a.m., the surveyor did not observe a posting of the licensee's emergency plan, emergency exit diagrams posted in conspicuous places on each floor, or emergency exit diagrams in residents' room. The licensee lacked evidence of the following required content: - a comprehensive program to include infectious diseases and pandemics; - a description of the population served by the licensee; - process for emergency preparedness (EP) cooperation with state and local EP officials/organizations; - procedure for tracking staff and residents; - subsistence needs for staff and residents during	0 680			

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0 680	Continued From page 7 emergency situation; - development of policies/procedures to address: - evacuation plan (not customized for the facility); - fire (not customized for the facility); - shelter in place; - a tracking system used to document locations or residents and staff; - the medical record documentation system to preserve resident information; - emergency staff strategies; and - the facilities role in providing care and treatment at alternative sites; - a communication plan that included: - arrangement with other facilities; - names and contact information for staff, resident physicians, other facilities; - contact information for federal, state, tribal, local EP staff, ombudsman; - primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management agencies; - a method of sharing information and medical documentation for residents; - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy; and - a method of sharing information from the emergency plan with residents and their families; - EP training and testing program; - EP training program for staff (including documentation of training provided); and - EP testing/annual testing requirements. On September 06, 2022, at 12:30 p.m., house manager (HM)-B stated staff were not familiar with Appendix Z (a section of the Centers for Medicare and Medicaid Services [CMS] State	0 680		

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0 680	Continued From page 8 Operations Manual which includes the emergency preparedness guidelines). HM-B also verified the licensee had not fully developed and implemented an emergency preparedness plan/program. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services;	0 730		

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0 730	Continued From page 9 (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to complete a discharge summary for one of one discharged resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	0 730		

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0 730	Continued From page 10 R1 began receiving assisted living services on May 3, 2021. R1's service plan dated July 28, 2021, indicated R1 received services, which included medication administration, assistance with meals, and weekly blood pressure check. R1's record lacked evidence a discharge summary had been completed. On September 06, 2022, at 12:30 p.m., registered nurse (RN)-A confirmed R1's record lacked a discharge summary including a summary of the resident's stay with the required content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
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: (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	0 780		

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0 780	Continued From page 11 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 complied with fire protection requirements. 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 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: On September 7, 2022, between 12:00 p.m. and 1:00 p.m., survey staff toured the facility with the housing manager (HM)-A. During the facility tour, survey staff observed that when smoke alarms were tested by the HM-A in the hallways outside the sleeping rooms, none of the other smoke alarms were activated. The HM-A confirmed during the tour interview that the smoke alarms were not interconnected. No further information was provided.	0 780		

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0 780	Continued From page 12	0 780		
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days			
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 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguisher. 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 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: On September 7, 2022, between 12:00 p.m. and 1:00 p.m., survey staff toured the facility with the housing manager (HM)-A. During the facility tour,	0 790		

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0 790	Continued From page 13 survey staff observed a portable fire extinguisher on the floor in the kitchen without a service tag attached indicating when maintenance or inspections had been performed. The HM-A stated that they did not know that maintenance was required to be completed annually for portable fire extinguishers by certified service personnel or that a monthly visual inspection needed to be performed by facility staff. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents 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 a	0 800		

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0 800	Continued From page 14 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: On September 7, 2022, between 12:00 p.m. and 1:00 p.m., survey staff toured the facility with the housing manager (HM)-A. During the facility tour, survey staff observed the following: 1. There was mold on the walls in basement bedrooms 4 and 5. 2. The crank mechanism was not working properly for the egress window in bedroom 3, which made opening the window difficult. Additionally, the HM-A could not open the window fully to provide a clear openable area for egress escape. 3. The smoke alarm in bedroom 4 was chirping. 4. The lights were not working in bedroom 5. The HM-A explained during the tour interview that the bulbs were burnt out and that the fixtures were operable. 5. There were deck boards and railings with exposed nails and screws on the ground in the backyard. 6. The sweep on the back storm door was loose which prevented this door from operating correctly. 7. There was a crack in the ceiling running the entire length of the living room and the finish was starting to peel in this area. 8. One side of the bi-fold door in the laundry room was broken. The HM-A confirmed during the tour interview that all of these items required correction. No further information was provided.	0 800		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36791	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/09/2022
NAME OF PROVIDER OR SUPPLIER SOLUTION HOME CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 9037 MOORLAND CHASE BROOKLYN CENTER, MN 55443		
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0 800	Continued From page 15 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique 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.	0 810		

Minnesota Department of Health

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0 810	Continued From page 16 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the required plans, training, and drills for fire safety and evacuation. 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 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: On September 7, 2022, between 12:00 p.m. and 1:00 p.m., survey staff toured the facility with the housing manager (HM)-A. During the facility tour, survey staff observed that evacuation maps were not posted in the facility showing the location and number of resident sleeping rooms. During the tour interview with the HM-A, they confirmed that evacuation maps were not posted and explained that these maps had been requested from the landlord. On September 7, 2022, at approximately 1:00 p.m., survey staff requested the following documents for review: 1. Fire safety and evacuation plans. 2. Records to support fire safety and evacuation training for employees. 3. Records to support annual resident training for the proper actions to take in the event of a fire including movement, evacuation, or relocation. 4. Completed evacuation drill logs or schedules. Documentation was requested by survey staff but	0 810		

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0 810	Continued From page 17 not provided. On September 7, 2022, at approximately 1:10 p.m., the HM-A explained during an interview that the licensee had not developed fire safety and evacuation plans for the facility. The HM-A stated that training had not been completed and that evacuation drills were not recorded. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced	01910		

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01910	Continued From page 18 by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include quantity and names of staff and other individuals involved in the disposition of medications for one of one discharged resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 started services May 2, 2021. R1's Service Plan dated July 28, 2021, indicated R1 received medication administration services daily. R1's medical record included a discharge summary which indicated R1 discharged from the facility on May 22, 2022, after receiving services for diagnoses including depression, bipolar and anxiety. R1's record lacked documentation of R1's disposition of medications to include name of the medication, strength, prescription number if applicable, quantity, to whom the medications were given, date of disposition, and the names of the staff and other individuals involved in the disposition.	01910		

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01910	Continued From page 19 On September 06,2022, at 1:43 p.m., a registered nurse (RN)-A stated the disposition of medications was not documented for discharged resident R1. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910			

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Food and Beverage Establishment Inspection Report

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Location:

Solution Home Care Llc
9037 Moorland Chase
Brooklyn Park, MN55443
Hennepin County, 27

Establishment Info:

ID #: 0039406
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 6127072736
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.

4-300 Equipment Numbers and Capacities

4-302.13B ** Priority 2 **

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

ESTABLISHMENT DOES NOT HAVE A MEASURING DEVICE THAT INDICATES THE FINAL UTENSIL SURFACE TEMPERATURE IN HIGH TEMPERATURE DISH MACHINE. PROVIDE. THERMOLABELS WERE LEFT ON-SITE. SEE COMMENTS.

Comply By: 09/14/22

4-300 Equipment Numbers and Capacities

4-302.14 ** Priority 2 **

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

NO TEST KIT ON-SITE TO MEASURE THE CONCENTRATION OF SANITIZER. DISCUSSED THE APPROVED FOOD CONTACT SURFACE SANITIZERS. PROVIDE AS DESCRIBED IN RULE ABOVE.

Comply By: 09/14/22

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

NO CERTIFIED FOOD PROTECTION MANAGER (CFPM) WAS EMPLOYED AT THIS ESTABLISHMENT. KHADRA ADAN IS IN THE PROCESS OF GETTING HER CFPM CERTIFICATE.

Comply By: 10/07/22

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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.

THE WHIRPOOL FRIDGE IN THE KITCHEN DID NOT HAVE A THERMOMETER. PROVIDE A THERMOMETER IN THE WARMEST PART OF THE FRIDGE AS DESCRIBED IN THE RULE ABOVE.

Comply By: 09/14/22

4-300 Equipment Numbers and Capacities

4-303.11B

MN Rule 4626.0721B Provide chemical sanitizers to sanitize equipment and utensils during all hours of operation.

NO CHEMICAL SANITIZERS ON-SITE. DISCUSSED WITH HOUSE MANAGER THE DIFFERENT APPROVED FOOD CONTACT SURFACE SANITIZERS. A FACT SHEET SENT WITH REPORT. PROVIDE CHEMICAL SANITIZERS TO SANITIZE EQUIPMENT, UTENSILS AND FOOD CONTACT SURFACES.

Comply By: 09/07/22

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.

THE POPCORN CEILING ABOVE THE KITCHEN CONTAINS A CRACK THAT GOES THROUGH THE KITCHEN TO THE LIVING ROOM. REPAIR.

Comply By: 01/09/23

Food and Equipment Temperatures

Process/Item: Ambient Temperature

Temperature: 35 Degrees Fahrenheit - Location: WHIRLPOOL REFRIGERATOR

Violation Issued: No

Total Orders	In This Report	Priority 1	Priority 2	Priority 3
		0	2	4

ALL FINDINGS ON THIS REPORT WERE DISCUSSED WITH HOUSE MANAGER, KHADRA ADAN AND HEALTH REGULATION DIVISION NURSE EVALUATOR, SAFIA HASSAN.

ESTABLISHMENT CURRENTLY DOES NOT HAVE ANY CLIENTS ON-SITE.

PER CONVERSATION WITH KHADRA, FOOD IS MADE FOR SAME DAY SERVICE. NO LEFTOVERS ARE KEPT.

CONTINUATION OF MN Rule 4626.0710B :

THE THERMOLABELS WILL HELP THE ESTABLISHMENT VERIFY THAT THEIR DISH MACHINE IS PROVIDING A FINAL UTENSIL SURFACE TEMPERATURE OF 160F OR ABOVE.

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Solution Home Care Llc

Food and Beverage Establishment Inspection Report

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ONE COMPARTMENT OF THE TWO COMPARTMENT SINK HAS BEEN ASSIGNED AS A HANDWASHING SINK AND THE OTHER AS A PREPARATION SINK.

DISCUSSED WITH KHADRA THE APPROVED TYPES OF SANITIZERS FOR FOOD CONTACT SURFACES. MAKING SURE THAT THE LABEL MENTIONS THAT IT CAN BE USED WITH NONPOROUS FOOD CONTACT SURFACES.

THE KITCHEN HAS RESIDENTIAL EQUIPMENT, WOOD CABINETS, POPCORN CEILING, WOOD FLOORS, LAMINATE COUNTERS, AND UNABLE TO VERIFY IF THE BASE CABINETS WERE NOT HOLLOW. PHYSICAL FACILITY ITEMS WILL BE MONITORED AT FUTURE INSPECTIONS.

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 1021221249 of 09/07/22.

Certified Food Protection Manager: _____

Certification Number: _____ Expires: ____ / ____ / ____

Inspection report reviewed with person in charge and emailed.

Signed: _____

KHADRA ADAN
HOUSE MANAGER

Signed: _____

Melissa Ramos
Environmental Health Specialist
Metro District Office
651-201-4495
Melissa.Ramos@state.mn.us