DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

February 8, 2023

Licensee
The Watkins House
341 4th Street North
Watkins, MN  55389

RE: Project Number(s) SL37576015

Dear Licensee:

On January 5, 2023, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the October 20, 2023, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

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. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,

Robert Dehler, Engineer Administrative Manager
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, MN  55164-0970
Telephone:  651-201-3710 Fax: 651-281-9796

Electronically Delivered

November 8, 2022

Administrator
The Watkins House
341 4th Street North
Watkins, MN 55389

RE: Project Number(s) SL37576015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on October 20, 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.

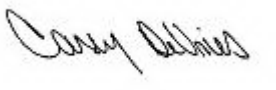
A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

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

Free from Maltreatment reconsideration requests should be addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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,



Casey DeVries, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: casey.devries@state.mn.us
Phone: 651-201-5917 Fax: 651-215-6894

HHH

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 37576 | A. BUILDING: _____ B. WING _____ | 10/20/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE WATKINS HOUSE | 341 4TH STREET NORTH WATKINS, MN 55389 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| 0 000 | Initial Comments<br><br>Initial comments<br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.<br><br>Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.<br><br>INITIAL COMMENTS:<br>SL37576015-0<br><br>On October 17, 2022, through October 20, 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 ten residents, all of whom received services under the provider's Assisted Living with Dementia Care 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 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.<br><br>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3. | |
| 0 480 SS=F | 144G.41 Subd 1 (13) (i) (B) Minimum requirements | 0 480 | | |

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| 0 480 | Continued From page 1<br><br>(13) offer to provide or make available at least the following services to residents:<br><br>(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:<br><br>(B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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).<br><br>The findings include:<br><br>Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated October 17, 2022, for the specific Minnesota Food Code deficiencies. | 0 480 | | |

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| 0 480 | Continued From page 2<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 480 | | |
| 0 630 SS=F | 144G.42 Subd. 6 (b) Compliance with requirements for reporting ma<br><br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure abuse prevention plans included all required assessments for two of two residents (R1, R2).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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).<br><br>The findings include: | 0 630 | | |

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| 0 630 | Continued From page 3<br><br>R1<br>R1's diagnoses included, multiple sclerosis, cerebral vascular accident (stroke) with left-sided weakness, chronic pain, and urinary retention.<br><br>On October 17, 2022, at 12:22 p.m., the surveyor observed R1 lying in bed and watching TV in R1's room. Later, at approximately 3:45 p.m., the surveyor observed unlicensed personnel (ULP)-E administer medications to R1 in R1's room.<br><br>On October 17, 2022, at 3:49 p.m., ULP-E informed the surveyor how much assistance R1 required and said R1 was very dependent upon staff to meet basic needs, including ADLs (activities of daily living) like dressing, grooming, perineal cares and feeding. ULP-E also mentioned R1 was combative at times and was verbally abusive to staff.<br><br>R1's Vulnerability Assessment/Abuse Prevention Plan, dated April 25, 2022, identified vulnerabilities including aggressive behavior toward others, inability to safely ambulate due to his medical diagnoses, chronic pain, and his environment not always being safe or clean.<br><br>R2<br>R2's diagnoses included mood disorder, sleep apnea, hypertension, and elevated cholesterol.<br><br>On October 18, 2022, at 9:49 a.m., the surveyor observed R2, while seated in his electric scooter, leave his room and navigate the hallway to the dining and living room area.<br><br>R2's Vulnerability Assessment/Abuse Prevention Plan, dated August 18, 2022, identified vulnerabilities including oxygen use, falls, safe/clean environment, ambulation concerns, | 0 630 | | |

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| 0 630 | Continued From page 4<br>and visual difficulties.<br><br>R1 and R2's abuse prevention plans lacked assessment of the residents' susceptibility to abuse by another individual, including other vulnerable adults.<br><br>On October 19, 2022, at 2:21 p.m., registered nurse (RN)-B stated both R1 and R2 were vulnerable to be abused by other residents, staff, visitors, and anybody, because of where the live and their health conditions. RN-B stated the current abuse plan form lacked assessment of the resident's susceptibility to abuse by others, including other vulnerable adults. RN-B said the same assessment form was used for all residents in the facility.<br><br>The licensee's 6.05 Individual Abuse Prevention Plan, dated August 1, 2021, indicated the licensee will develop and implement an individual abuse prevention plan for each vulnerable adult. The plan would contain 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.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 630 | | |
| 0 680 SS=F | 144G.42 Subd. 10 Disaster planning and emergency preparedness<br><br>(a) The facility must meet the following requirements: | 0 680 | | |

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| 0 680 | Continued From page 5<br>(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;<br>(2) post an emergency disaster plan prominently;<br>(3) provide building emergency exit diagrams to all residents;<br>(4) post emergency exit diagrams on each floor; and<br>(5) have a written policy and procedure regarding missing tenant residents.<br>(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.<br>(c) The facility must meet any additional requirements adopted in rule.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to have a written emergency preparedness plan with all required content. In addition, the licensee failed to ensure the clinical director reviewed their missing person policy at least quarterly. This had the potential to affect all ten residents, staff, and any visitors to the facility.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected | 0 680 | | |

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| 0 680 | Continued From page 6<br>or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>The licensee's emergency preparedness (EP) plan, undated, lacked the following content requirements:<br>-description of the population served by licensee;<br>-process for emergency preparedness cooperation with state and local EP officials/organizations;<br>-subsistence needs for staff and residents during emergency situations including:<br>-food, water, medical and pharmaceutical supplies;<br>-safe/sanitary storage of provisions;<br>-emergency lighting;<br>-fire detection, extinguishing, alarm systems; and<br>-sewage and waste disposal;<br>-procedure for tracking staff and residents;<br>-development of all policies/procedures, based on assessment; and additional policies for:<br>-sheltering in place;<br>-handling medical documents;<br>-handling and use of volunteers;<br>-arrangement with other faculties or entities;<br>-development of a communication plan, including:<br>-names and contact information for staff, resident's physicians; (partial listing was found in provided documents);<br>-emergency officials contact information for federal, stated tribal, regional & local EP staff;<br>-methods for sharing information;<br>-sharing information on occupancy and needs; and<br>-family notifications.<br>-EP training and testing program;<br>-EP training program for staff (including | 0 680 | | |

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| 0 680 | Continued From page 7<br>documentation of training provided); and<br>-annual EP testing requirements.<br><br>On October 20, 2022, at 2:38 p.m., the surveyor reviewed the EP plan with licensed assisted living director in residence/registered nurse (LALDIR/RN)-A, who stated there was a lack of resident assessment, components of a communication plan, and an unsigned agreement with another facility. LALDIR/RN-A also stated there were missing procedures regarding the handling of medical documents, tracking of staff and residents, sheltering in place, the use of volunteers, methods for sharing information and occupancy needs and family notifications. LALDIR/RN-A stated the EP plan was a big and on-going project and they would work to improve the plan. LALDIR/RN-A also stated there was no documentation or other evidence their missing resident policy and plan was reviewed and updated and verified the August 1, 2021, as the most current review.<br><br>The licensee's 9.01 Emergency Preparedness Plan - Appendix Z Compliance policy, dated August 1, 2021, indicated it is the intent the assisted living facility has in place an effective and complaint emergency preparedness plan, aligned with the Centers for Medicare and Medicaid services State Operation Manual Appendix Z. The policy indicated key elements of the plan included four primary components: 1. Risk assessment and planning; 2. Policies and procedures; 3. A communication plan; 4. Staff training and exercise/drills. The policy indicated the facility will utilize a VA (vulnerability assessment) tool, have policies and procedures designed to align with Appendix Z, and a communication plan. | 0 680 | | |

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| 0 680 | Continued From page 8<br><br>The licensee's 2028 Missing Resident policy, dated August 1, 2021, lacked indication the plan was reviewed, with any documented changes, at least quarterly.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 0 680 | | |
| 0 730 SS=F | 144G.43 Subd. 3 Contents of resident record<br><br>Contents of a resident record include the following for each resident:<br>(1) identifying information, including the resident's name, date of birth, address, and telephone number;<br>(2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative;<br>(3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known;<br>(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;<br>(5) the resident's advance directives, if any;<br>(6) copies of any health care directives, guardianships, powers of attorney, or conservatorships;<br>(7) the facility's current and previous assessments and service plans;<br>(8) all records of communications pertinent to the resident's services;<br>(9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to | 0 730 | | |

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| 0 730 | Continued From page 9<br>the appropriate supervisor or health care professional;<br>(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;<br>(11) documentation that services have been provided as identified in the service plan;<br>(12) documentation that the resident has received and reviewed the assisted living bill of rights;<br>(13) documentation of complaints received and any resolution;<br>(14) a discharge summary, including service termination notice and related documentation, when applicable; and<br>(15) other documentation required under this chapter and relevant to the resident's services or status.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure the resident record included documentation of significant changes for one of one resident (R1) who had a pressure ulcer wound. In addition, the licensee failed to ensure documentation of all provided services was completed for two of two residents (R1, R2).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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). | 0 730 | | |

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| 0 730 | Continued From page 10<br>The findings include:<br><br>LACK OF WOUND DOCUMENTATION<br><br>R1 was admitted for services April 21, 2022.<br><br>R1's diagnoses included multiple sclerosis, cerebral vascular accident (stroke) with left-sided weakness, chronic pain, and urinary retention.<br><br>R1's nursing assessment, dated April 21, 2022, indicated R1 had a stage 3 (pressure ulcer wound indicating full thickness skin loss with no muscle or bone exposed, but undermining and tunneling may be present) sacral wound. Although the assessment indicated the resident had a stage 3 sacral wound, the assessment lacked description of the location, size, and staging of R1's wound. Subsequent nursing assessments dated May 5, 2022, July 21, 2022, August 30, 2022, and September 21, 2022, provided no additional information related to R1's wound.<br><br>On October 19, 2022, at 9:34 a.m., the surveyor observed unlicensed personnel (ULP)-D assist registered nurse (RN)-B provide wound care to R1. After positioning R1 on his left side, RN-B removed an ABD (abdominal) gauze dressing from a wound located below and to the left of R1's coccyx, the dressing had a minimal amount of red-colored drainage. The wound was oval shaped, approximately two inches in width and about one inch in height, little depth, with wound edges intact and was dark pink in color. The surveyor noted no odor. RN-B cleansed the site with wound cleanser, patted it dry with a gauze pad, applied skin barrier, then applied a new ABD pad for dressing.<br><br>On October 19, 2022, at 9:41 a.m., RN-B | 0 730 | | |

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| 0 730 | Continued From page 11<br><br>described R1's wound to be stage 3 pressure ulcer that measured 3.2 centimeters wide by 2 centimeters in length and 0.2 millimeters depth. RN-B stated the wound edges were intact, the old dressing had a minimal amount of sanguineous (bloody) drainage, and the wound had no tunneling or undermining.<br><br>R1's record lacked at least weekly monitoring of the wound to include location, description (including measured size, drainage, odors) of the wound and additional assessment and analysis of the progression of R1's wound with response to any treatment provided.<br><br>On October 19, 2022, at 2:27 p.m., RN-B stated she should have begun documenting the wound when R1 was admitted, saying monitoring the pressure ulcer "is new to me." RN-B said she also assumed that since hospice was involved in R1's care, they were monitoring the wound. RN-B stated since she's provided care for R1, the wound was improving, but again acknowledged the lack of documentation regarding its progress and said, "I understand that."<br><br>LACK OF DOCUMENTATION OF SERVICES<br><br>R1<br>R1's service plan, dated April 21, 2022, indicated services included: daily medication administration, 3x (times) feeding, weekly bathing, twice daily hygiene, dressing, grooming and oral care assistance, assistance with mobility, treatment, personal laundry, and linens (weekly), and housekeeping (daily).<br><br>On October 17, 2022, at 12:54 p.m., the surveyor observed ULP-D feed R1 a snack in R1's room. | 0 730 | | |

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| 0 730 | Continued From page 12<br><br>R1's October 2022 documentation of services indicated staff documented R1's medication and treatment services in the medication administration record (MAR) and they documented R1's daily services on an untitled shared form which included all residents and services.<br><br>R2<br>R2's service plan, dated August 18, 2022, indicated services included: daily medication and treatments administration, treatments 3x (times) meal, 2 times weekly bathing, twice daily and prn (as needed) hygiene/grooming including oral care, toileting reminders every 2 hours during day and every 4 hours a night, weekly personal laundry and linens, and daily housekeeping.<br><br>On October 17, 2022, at 2:19 p.m., the surveyor observed ULP-C administer afternoon medications to R2.<br><br>R2's October 2022 documentation of services indicated staff documented R2's medication and treatment services in the medication administration record (MAR) and they documented R2's daily services on an untitled shared form which included all residents and services.<br><br>The untitled form used to document R1 and R2's resident services (other than medication and treatments) lacked evidence staff documented laundry and housekeeping services provided for the residents.<br><br>On October 20, 2022, at 3:44 p.m., licensed assisted living director in residence/registered nurse (LALDIR/RN)-A stated there was no documentation of laundry and housekeeping | 0 730 | | |

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| 0 730 | Continued From page 13<br>services for R1, R2, or for any resident. LALDIR/RN-A said the form used to document resident services, aside from medication and treatments, were daily forms, one for each shift, that listed all residents and all services. LALDIR/RN-A said staff documented on those forms every shift and also, the forms were for each month, but were not stored as part of each resident's individual record. LALDIR/RN-A acknowledged there lacked a record of the documentation of services that was unique for each resident. LALDIR/RN-A said RN-B was working on a form, like the MAR, to document each resident's services.<br><br>The licensee's 2.37 Resident Record - Documentation policy, dated August 1, 2021, indicated staff authorized to document in a resident record will do so for all medications, services, treatments, and therapies for each resident. Staff will also document other important and pertinent information relating to each resident to include new problems and change in condition.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 730 | | |
| 0 810 SS=F | 144G.45 Subd. 2 (b)-(f) Fire protection and physical environment<br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:<br>(1) location and number of resident sleeping rooms;<br>(2) employee actions to be taken in the event of a fire or similar emergency; | 0 810 | | |

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| 0 810 | Continued From page 14<br>(3) fire protection procedures necessary for residents; and<br>(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.<br>(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.<br>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.<br>(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.<br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to develop and maintain fire safety and evacuation plans, failed to provide required training to residents and employees for fire safety and evacuation, and failed to conduct required employee evacuation drills. This had the potential to affect all current residents, staff, and visitors to the facility.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a | 0 810 | | |

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| 0 810 | Continued From page 15<br>resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents).<br><br>The findings include:<br><br>During interview on October 19, 2022, at 3:45 p.m., the owner (OWN)-G stated they had not developed their fire safety and evacuation plans to include specific procedures for residnet movement, evacuation or relocation. They had not identified or documented any unique or unusual resident needs for movement or evacuation by time of the survey.<br><br>Review of the fire safety policy showed the following:<br><br>1. No evacuation plan or documentation on specific procedures for the residents including procedures for their movements, and relocation during a fire or similar emergency. No written instructions for addressing any unique situation during an evacuation, especially for residents who need assistance during an evacuation.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 810 | | |
| 0 820 SS=F | 144G.45 Subd. 2 (g) Fire protection and physical environment<br><br>(g) Existing construction or elements, including assisted living facilities that were registered as | 0 820 | | |

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| 0 820 | Continued From page 16<br><br>housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to ensure the physical facility elements did not constitute a distinct hazard to life. The licensee haddoor lock hardware that required a code to exit the home on the egress side of all the doors leading outside. This had the potential to affect all occupied residents, staff, and visitors because timely evacuation would not be possible in the event of a fire or other life-threatening emergencies.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>On October 19, 2022, approximately from 2:45 p.m. to 3:45 p.m., survey staff toured the home with the owner (OWN)-G. During the tour, survey staff observed each door in the facility that lead | 0 820 | | |

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| 0 820 | Continued From page 17<br>outside the building had a lock that required a code to exit. Survey staff verified with OWN-G that the locks were not tied into the building fire alarm system or sprinkler system and would not default to an unlocked (fail-safe) position if the power went out.<br><br>Survey staff explained to OWN-G that the locks in the path of egress that require a code would cause a delay in the proper exiting of the home during a fire or similar emergency.<br><br>OWN-G verbally confirmed survey staff observations during the facility tour.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 820 | | |
| 0 930 SS=C | 144G.50 Subd. 2 (d-e; 1-4) Contract information<br><br>(d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints.<br>(e) The contract must include a clear and conspicuous notice of:<br>(1) the right under section 144G.54 to appeal the termination of an assisted living contract;<br>(2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer;<br>(3) contact information for the Office of Ombudsman for Long-Term Care, the | 0 930 | | |

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| 0 930 | Continued From page 18<br><br>Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints;<br>(4) the resident's right to obtain services from an unaffiliated service provider;<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content for two of two residents (R1, R2).<br><br>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 of the residents).<br><br>The findings include:<br><br>R1 and R2's assisted living contracts lacked contact information for the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints.<br><br>R1<br>R1's service plan, dated April 21, 2022, indicated services included: daily medication administration, feeding, bathing, daily hygiene, dressing, grooming and oral care assistance, assistance with mobility, treatment, personal laundry and linens, and housekeeping.<br><br>R1's Assisted Living Agreement was signed and dated by the resident April 20, 2022. | 0 930 | | |

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| 0 930 | Continued From page 19<br><br>R2<br>R2's service plan, dated August 18, 2022, indicated services included: medication and treatments administration, meals and snacks, weekly bathing, assistance with hygiene/grooming including oral care, toileting reminders, personal laundry, linens, and housekeeping.<br><br>R1's Assisted Living Agreement was signed and dated by the resident August 18, 2022.<br><br>On October 19, 2022, at 1:03 p.m., licensed assisted living director in residence/registered nurse (LALDIR/RN)-A said they used the same contract template for all residents and going forward they would revise it and provide residents an updated version.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 0 930 | | |
| 0 940 SS=C | 144G.50 Subd. 2 (e; 5-7) Contract information<br><br>(5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including:<br>(i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers;<br>(ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b);<br>(iii) whether there is a limit on the number of | 0 940 | | |

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| 0 940 | Continued From page 20<br>people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided;<br>(iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required;<br>(v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent;<br>(vi) a statement that residents may be eligible for assistance with rent through the housing support program; and<br>(vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program;<br>(6) the contact information to obtain long-term care consulting services under section 256B.0911; and<br>(7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content for two of two residents (R1, R2).<br><br>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 of the residents). | 0 940 | | |

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| 0 940 | Continued From page 21<br><br>The findings include:<br><br>R1 and R2's assisted living contracts lacked the following content:<br>-a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including:<br>-whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b);<br>-whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided;<br>-whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required;<br>-a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent;<br>-a statement that residents may be eligible for assistance with rent through the housing support program;<br>-Toll-free phone number for MAARC (Minnesota Adult Abuse Reporting Center).<br><br>R1<br>R1's service plan, dated April 21, 2022, indicated services included: daily medication administration, feeding, bathing, daily hygiene, dressing, grooming and oral care assistance, assistance with mobility, treatment, personal laundry and linens, and housekeeping.<br><br>R1's Assisted Living Agreement, signed and | 0 940 | | |

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| 0 940 | Continued From page 22<br>dated by the resident April 20, 2022, lacked content listed above.<br><br>R2<br>R2's service plan, dated August 18, 2022, indicated services included: medication and treatments administration, meals and snacks, weekly bathing, assistance with hygiene/grooming including oral care, toileting reminders, personal laundry, linens, and housekeeping.<br><br>R1's Assisted Living Agreement, signed and dated by the resident August 18, 2022, lacked content listed above.<br><br>On October 19, 2022, at 1:03 p.m., licensed assisted living director in resident/registered nurse (LALDIR/RN)-A said they used the same contract template for all residents and going forward they would revise it and provide residents an updated version.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 0 940 | | |
| 01060 SS=D | 144G.52 Subd. 9 Emergency relocation<br><br>(a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination.<br>(b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: | 01060 | | |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| 01060 | Continued From page 23<br>(1) the reason for the relocation;<br>(2) the name and contact information for the location to which the resident has been relocated and any new service provider;<br>(3) contact information for the Office of Ombudsman for Long-Term Care;<br>(4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and<br>(5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal.<br>(c) The notice required under paragraph (b) must be delivered as soon as practicable to:<br>(1) the resident, legal representative, and designated representative;<br>(2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and<br>(3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days.<br>(d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.<br><br>This MN Requirement is not met as evidenced by:<br>Based interview and record review licensee failed to ensure notice with required content was provided to the resident/representative for one of one resident (R1) who had an emergency relocation out of the facility. | 01060 | | |

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| 01060 | Continued From page 24<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).<br><br>The findings include:<br><br>R1's service plan, dated April 21, 2022, indicated services included: daily medication and treatments, feeding, bathing, twice daily hygiene, dressing, grooming and oral care assistance, assistance with mobility, treatment, personal laundry, linens, and housekeeping.<br><br>R1's progress notes indicated:<br>-July 16, 2022, (Saturday) R1 was sent to the hospital and facility was updated by hospice staff that the R1's CT (computerized tomography, a kind of body scan to obtain detailed internal images of the body) showed pneumonia and were awaiting blood cultures.<br>-July 16, 2022, facility updated from hospital and R1 will be on antibiotics for a few days and possible discharge Monday or Tuesday.<br>-July 24, 2022, R1 was discharged from the hospital and returned to the assisted living facility.<br><br>Although R1 was relocated from the facility from July 16, 2022, to July 24, 2022, or eight days, R1's record lacked evidence a written emergency relocation notice was provided to the resident and resident's representative that at minimum contained:<br>- the name and contact information for the location to which the resident has been relocated | 01060 | | |

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| 01060 | Continued From page 25 | 01060 | | |

and any new service provider;
- contact information for the Office of Ombudsman for Long-Term Care;
- if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and
- a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal.

On October 19, 2022, at 1:33 p.m., registered nurse (RN)-B stated R1 was sent out of the facility and hospitalized from July 16, 2022, through July 24, 2022, for eight days. RN-B said as far as she knew, R1 was not given any notice and deferred to other nurse/assisted living director.

On October 19, 2022, at 2:33 p.m., assisted living director in residence/registered nurse (LALDIR/RN)-A stated R1 received no notice that included content as described in the statute and said, "I had no clue" a notice was required and stated they were sure the ombudsman was not notified.

The licensee's 1.23 Emergency Relocation policy, dated August 1, 2021, indicated the licensee may remove a resident from the facility in an emergency due to resident's urgent medical needs and that an emergency relocation is not a termination. The policy indicated the facility will provide written notice as soon as practicable to the resident, resident's representative, designated representative, office of Ombudsman and (if applicable) case manager and the notice would

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| 01060 | Continued From page 26<br>include the items listed above.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 01060 | | |
| 01470 SS=D | 144G.63 Subd. 2 Content of required orientation<br><br>(a) The orientation must contain the following topics:<br>(1) an overview of this chapter;<br>(2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person;<br>(3) handling of emergencies and use of emergency services;<br>(4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC);<br>(5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;<br>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person;<br>(7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints;<br>(8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or | 01470 | | |

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| 01470 | Continued From page 27<br>other relevant advocacy services; and<br>(9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure.<br>(b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:<br>(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication;<br>(2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or<br>(3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure orientation to the assisted living facility licensing requirements and regulations included all required content and was completed timely for one of three employees (registered nurse (RN)-B).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and | 01470 | | |

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| 01470 | Continued From page 28<br>was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).<br><br>The findings include:<br><br>During the entrance conference on October 17, 2022, at 9:41 a.m., licensed assisted living director in residence/registered nurse (LALDIR/RN)-A stated she was familiar with the statutes and regulations for assisting living, effective August 1, 2021.<br><br>RN-B was hired April 21, 2022, to provide assisted living services to the licensee's residents.<br><br>On October 17, 2022, at 9:41 a.m., the surveyor observed RN-B provide wound care and repositioning for a resident.<br><br>The training records indicated RN-B completed orientation on August 1, 2022, which was more than three months after RN-B began providing direct care services. The trainging records lacked evidence RN-B was oriented to the new assisted living licensing requirements in the following areas:<br>-reporting of maltreatment of vulnerable adults or minors;<br>-assisted living bill of rights;<br>-handling of resident complaints, reporting of complaints, where to report;<br>-consumer advocacy services; and<br>-review of types of assisted living services the employee will provide and provider's scope of license.<br><br>On October 20, 2022, at 2:07 p.m., LALDIR/RN-A | 01470 | | |

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| 01470 | Continued From page 29<br>said RN-B began orientation for a different license for the company and thought the orientation would carry over to this license. LALDIR/RN-A stated RN-B's orientation lacked the necessary content and was not completed on time.<br><br>The licensee's 5.01 Orientation of Staff and Supervisors & Content policy, dated August 1, 2021, indicated all staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The policy directed orientation must be completed once for each staff and is not transferable to anther home care provider. The policy indicated orientation included the topics listed above.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01470 | | |
| 01790 SS=F | 144G.71 Subd. 10 Medication management for residents who will<br><br>(2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days;<br>(3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and<br>(4) the medications must be placed in a medication container or containers appropriate to | 01790 | | |

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| 01790 | Continued From page 30<br>the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled.<br>(b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if:<br>(1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and<br>(2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address:<br>(i) the type of container or containers to be used for the medications appropriate to the provider's medication system;<br>(ii) how the container or containers must be labeled;<br>(iii) written information about the medications to be provided;<br>(iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information;<br>(v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative;<br>(vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed | 01790 | | |

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| 01790 | Continued From page 31<br>personnel; and<br>(vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) developed written procedures for the unlicensed personnel (ULP) providing medications to residents having unplanned time away when the licensed nurse was not available. This had the potential to affect all ten current residents of the facility.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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).<br><br>The findings include:<br><br>During the entrance conference on October 17, 2021, at 11:04 a.m., licensed assisted living director in residence/registered nurse (LALDIR/RN)-A stated they provided medication and treatment management services to their residents.<br><br>On October 18, 2022, between approximately 6:43 a.m. and 7:34 a.m., the surveyor observed ULP-D administer morning medications to five | 01790 | | |

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| 01790 | Continued From page 32<br>residents.<br><br>The licensee's 7.01 Medication Management - Planned & Unplanned Time Away policy, dated August 1, 2021, addressed how unlicensed personnel (ULP) may give medications to residents who have unplanned time away from home. The policy indicated, when the facility provides medication management services and controls access, ULPs may give medications to the resident/representative if the RN has delegated this task and has developed written procedures for the ULP.<br><br>The licensee lacked a written procedure for giving accurate and current medications to residents for unplanned times away from home.<br><br>The policy indicated a written procedure would include:<br>-the type of container or containers to be used for the medication appropriate to the provider's medication system;<br>-how the container or containers must be labeled;<br>-written information about the medications to be provided;<br>-how the ULP must document in the resident's record that medications have been provided, including documenting the date the medications where provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information;<br>-how the RN would be notified that medications have been provided and whether the RN needs to be contacted before the medications are given to the resident or the designated representative;<br>-a review by the RN of the completion of this task to verify that this task was completed accurately | 01790 | | |

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| 01790 | Continued From page 33<br>by the ULP; and<br>-how the ULP must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each medication returned.<br><br>On October 20, 2022, at 2:51 p.m., licensed assisted living director in residence/registered nurse (LALDIR//RN)-A stated they have a policy and talk about the procedure as part of medication training, but had no written procedure.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01790 | | |
| 01940 SS=E | 144G.72 Subd. 3 Individualized treatment or therapy managemen<br><br>For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following:<br>(1) a statement of the type of services that will be provided;<br>(2) documentation of specific resident instructions relating to the treatments or therapy administration;<br>(3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel;<br>(4) procedures for notifying a registered nurse or | 01940 | | |

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| 01940 | Continued From page 34<br>appropriate licensed health professional when a problem arises with treatments or therapy services; and<br>(5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure the registered nurse developed an individualized treatment management plan with all required content for two of two residents (R1, R2) who had ordered treatments.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).<br><br>The findings include:<br><br>During the entrance conference on October 17, 2021, at 11:04 a.m., licensed assisted living director in residence/registered nurse (LALDIR/RN)-A stated they provided medication and treatment management services to their | 01940 | | |

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| 01940 | Continued From page 35<br>residents.<br><br>R1<br>R1's diagnoses included, multiple sclerosis, cerebral vascular accident (stroke) with left-sided weakness, chronic pain, and urinary retention.<br><br>R1's service plan, dated April 21, 2022, indicated services included: daily medication and treatments, feeding, bathing, twice daily hygiene, dressing, grooming and oral care assistance, assistance with mobility, treatment, personal laundry, linens, and housekeeping.<br><br>R1' treatment management plan, dated April 21, 2021, included tasks for catheter care and wound care.<br><br>R1's prescriber orders dated July 24, 2022, directed to place padded boots for feet/heels.<br><br>On October 17, 2022, at 12:42 p.m., the surveyor observed unlicensed personnel (ULP)-D administer medications to R1. ULP-D checked the placement of R1's bilateral, pressure-relieving heel protection boots, and adjusted the pillow between R1's legs.<br><br>On October 17, 2022, at 12:48 p.m., ULP-D stated R1 had the cloth boots to protect his feet, skin, heels, and that R1 has had them since he moved in and wore them all the time when in bed. ULP-D said they would remove them to clean his feet and check for any skin breakdown. ULP-D said there was nothing in the MAR (medication administration record) that explained exactly what staff were supposed to do with the heel boots.<br><br>R1's record lacked a treatment management plan for use of pressure-reliving boots that included: | 01940 | | |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 01940 | Continued From page 36<br>-statement of the type of services that will be provided;<br>-documentation of specific resident instructions relating to treatment or therapy;<br>-identification of the treatment or therapy tasks that may be delegated to unlicensed personnel;<br>-procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and<br>-any resident-specific requirements relating to documentation of treatment or therapy received.<br><br>R2<br>R2's diagnoses included mood disorder, sleep apnea, hypertension, and elevated cholesterol.<br><br>R2's service plan, dated August 18, 2022, indicated services included: medication and treatments administration, treatments, meals, weekly bathing, twice daily and prn (as needed) hygiene/grooming including oral care, toileting reminders every 2 hours during day and every 4 hours a night, personal laundry, linens, and daily housekeeping.<br><br>R2's treatment management plan, dated August 18, 2022, included tasks for daily blood glucose checks and CPAP (continuous positive airway pressure, a device used to treat sleep apnea).<br><br>R2's prescriber orders dated July 24, 2022, directed to use CPAP.<br><br>On October 18, 2022, at 10:09 a.m., the surveyor observed R2 lying in his bed with the CPAP device in place. R2 said he used the CPAP for many years and, "I manage it mostly by myself." R2 said the staff clean the CPAP, but was not sure how often and staff also changed the long | 01940 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 37576 | A. BUILDING: _____ B. WING _____ | 10/20/2022 |

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|---|---|---|---|---|
| 01940 | Continued From page 37<br>tubing, "maybe every month."<br><br>On October 19, 2022, at 11:59 a.m., ULP-D said R2 was pretty much independent with his CPAP, and staff were only supposed to clean the part that fits over R2's mouth, "I just take it clean it a couple times a week." ULP-D said she did not know if the tubing was changed or who was responsible for that. ULP-D looked at R2's treatments in the MAR and said there was nothing about the use of the CPAP, such as how or when to clean it, when to change tubes, or if staff should document when R2 has the CPAP on.<br><br>R2's record lacked a treatment management plan for use of the CPAP that included:<br>-documentation of specific resident instructions relating to treatment or therapy;<br>-procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and<br>-any resident-specific requirements relating to documentation of treatment or therapy received.<br><br>On October 19, 2022, at 1:51 p.m., registered nurse (RN)-B reviewed R2's treatment plan regarding the CPAP and stated staff were to clean the mouthpiece weekly and the tubing was changed monthly. RN-B stated R2's treatment plan or MAR had no specific instructions regarding the maintenance of the CPAP and also there was no documentation of the treatment or description of what staff were doing for R2. RN-B also stated R1's treatment plan did not address the use of the foot and heel boots and lacked instructions for the treatment, who was responsible, and documentation the treatment was completed. | 01940 | | |

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| 01940 | Continued From page 38<br><br>The licensee's 7.05 Treatment & Therapy Management Plan policy, dated August 1, 2021, indicated for each resident receiving ordered or prescribed treatment services, the facility will prepare and include in the service plan a written statement of the treatment services that will be provided to the resident. The policy indicated the items listed above would be included in a resident's treatment management plan.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01940 | | |
| 01960 SS=E | 144G.72 Subd. 5 Documentation of administration of treatments<br><br>Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure ordered treatments were documented in the record for two of two residents (R1, R2) who had ordered treatments. | 01960 | | |

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|---|---|---|---|---|
| 01960 | Continued From page 39<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).<br><br>The findings include:<br><br>R1<br>R1's diagnoses included, multiple sclerosis, cerebral vascular accident (stroke) with left-sided weakness, chronic pain, and urinary retention.<br><br>R1's prescriber orders dated July 24, 2022, directed to place padded boots for feet/heels.<br><br>On October 17, 2022, at 12:42 p.m., the surveyor observed unlicensed personnel (ULP)-D administer medications to R1. ULP-D checked the placement of R1's bilateral, pressure-relieving heel protection boots, and adjusted the pillow between R1's legs.<br><br>On October 18, 2022, at 12:30 p.m., the surveyor asked ULP-D where the treatment for R1's heel boots was documented. ULP-D reviewed R1's medication administration record (MAR) where R1's other treatments were recorded, and stated, "we're not documenting this for [R1] and I don't know why."<br><br>R2<br>R2's diagnoses included mood disorder, sleep apnea, hypertension, and elevated cholesterol. | 01960 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| 01960 | Continued From page 40<br><br>R2's treatment management plan, dated August 18, 2022, included tasks for daily blood glucose checks and CPAP (continuous positive airway pressure, a device used to treat sleep apnea).<br><br>R2's prescriber orders dated July 24, 2022, directed to use CPAP.<br><br>On October 18, 2022, at 10:09 a.m., the surveyor observed R2 lying in his bed with the CPAP device in place. R2 said he used the CPAP for many years and, "I manage it mostly by myself." R2 said the staff clean the CPAP, but was not sure how often and staff also changed the long tubing, "maybe every month."<br><br>On October 19, 2022, at 12:05 p.m., ULP-D reviewed R2's MAR and treatment section. ULP-D said there were no directions about the use of the CPAP, such as cleaning or changing tubes, or that staff were supposed to document when R2 wore it.<br><br>On October 10, 2022, at 1:51 p.m., registered nurse (RN)-B stated there was no documentation for neither R1's foot/heel boots treatment nor R1's CPAP treatment.<br><br>The licensee's 7.05 Treatment & Therapy Management Plan policy, dated August 1, 2022, indicated the licensee would develop and maintain a current individual treatment and therapy management record for each resident, and the record would include verification that all treatment and therapy was administered as prescribed.<br><br>The licensee's 2.37 Resident Record - Documentation policy, dated August 1, 2021, indicated staff providing assisted living services | 01960 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| 01960 | Continued From page 41<br>were to document, daily, medications, services, treatment, or therapies provided to each resident.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01960 | | |
| 02140 SS=F | 144G.83 Subd. 3 Supervising staff training<br><br>Persons providing or overseeing staff training must have experience and knowledge in the care of individuals with dementia, including:<br>(1) two years of work experience related to Alzheimer's disease or other dementias, or in health care, gerontology, or another related field; and(2) completion of training equivalent to the requirements in this section and successfully passing a skills competency or knowledge test required by the commissioner.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure the designated person overseeing staff training in the care of individuals with dementia, licensed assisted living director in residence/registered nurse (LALDIR/RN)-A, had documented evidence of competency or knowledge test required by the commissioner. This had the potential to affect all residents and staff of the facility.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems | 02140 | | |

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| 02140 | Continued From page 42<br>are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>The facility was licensed as an assisted living facility with dementia care.<br><br>During the entrance conference on October 17, 2022, at approximately 9:41 a.m., LALDIR/RN-A stated she was in charge of overseeing the dementia-care training for staff. LALDIR/RN-A stated she had the required work experience related to Alzheimer's disease and also completed at least eight hours of dementia-care training.<br><br>LALDIR/RN-A's training transcript indicated she had completed the requisite number of required hours in dementia care. However, LALDIR/RN-A's record lacked evidence of demonstrated competency to be the person in charge of overseeing staff training.<br><br>On October 20, 2022, at 12:20 p.m., LALDIR/RN-A stated she did not have a training certificate to verify knowledge and demonstrate competency related to dementia care. LALDIR/RN-A stated she was unaware of the requirement.<br><br>The licensee's 5.03 Dementia Training policy, dated August 1, 2021, indicated all facility staff were required to complete dementia training at the time of hire and annually thereafter. The policy did not address the requirements of of the person(s) providing or overseeing staff training for assisted living facilities with dementia care. | 02140 | | |

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|---|---|---|---|---|
| 02140 | Continued From page 43<br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 02140 | | |
| 02170 SS=F | 144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA<br><br>(b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following:<br>(1) past and current interests;<br>(2) current abilities and skills;<br>(3) emotional and social needs and patterns;<br>(4) physical abilities and limitations;<br>(5) adaptations necessary for the resident to participate; and<br>(6) identification of activities for behavioral interventions.<br>(c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs.<br>(d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to:<br>(1) occupation or chore related tasks;<br>(2) scheduled and planned events such as entertainment or outings;<br>(3) spontaneous activities for enjoyment or those that may help defuse a behavior;<br>(4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music;<br>(5) spiritual, creative, and intellectual activities; | 02170 | | |

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| 02170 | Continued From page 44<br>(6) sensory stimulation activities;<br>(7) physical activities that enhance or maintain a resident's ability to ambulate or move; and<br>(8) outdoor activities.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to develop an activity plan for two of two residents (R1, R2) who received services under the facility's assisted living with dementia care license.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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).<br><br>The findings include:<br><br>During the entrance conference on October 17, 2022, at 9:41 a.m., licensed assisted living director in residence/registered nurse (LALDIR/RN)-A stated they held an assisted living with dementia care license.<br><br>R1<br>R1's diagnoses included multiple sclerosis, cerebral vascular accident (stroke) with left-sided weakness, chronic pain, and urinary retention.<br><br>On October 17, 2022, at 12:22 p.m., they surveyor observed R1 lying in bed and watching TV. | 02170 | | |

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|---|---|---|---|---|
| 02170 | Continued From page 45<br>R2<br>R2's diagnoses included mood disorder, sleep apnea, hypertension, and elevated cholesterol.<br><br>On October 18, 2022, at 9:49 a.m., the surveyor observed R2 at the dining table while seated in an electric scooter. R2 was snacking on grapes, conversing with other residents at the table and working on a picture-search activity.<br><br>R1 and R2's records lacked an individualized activity plan, based on evaluation, that included:<br>-occupation or chore related tasks;<br>-scheduled and planned events such as entertainment or outings;<br>-spontaneous activities for enjoyment or those that help defuse a behavior;<br>-one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music;<br>-spiritual, creative and intellectual activities;<br>-sensory stimulation activities;<br>-physical activities that enhance or maintain a residents' ability to ambulate or move; and<br>-outdoor activities.<br><br>On October 19, 2022, at 2:35 p.m., LALDIR/RN-A stated they evaluate and assess residents for activities, had scheduled daily activities planned, but that the residents directed most of their own free time. LALDIR/RN-A said they had not developed an activity plan for R1, R2, or for any of the residents.<br><br>The licensee's 3.05 ALDC (assisted living dementia care) Life Enrichment Programs, Activities and Outdoor Space policy, dated August 1, 2021, indicated each resident would be evaluated for activities and an individualized activity plan would be developed for each resident | 02170 | | |

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| 02170 | Continued From page 46<br>based on their activity evaluation.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 02170 | | |

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

Type: Full
Date: *10/17/22*
Time: 11:45:04
Report: 7930221167

# Food and Beverage Establishment Inspection Report



**Location:**
The Watkins House
341 4th Street North
Watkins, MN55389
Meeker County, 47

**Establishment Info:**
ID #: 0038453
Risk:
Announced Inspection: No

**License Categories:**

Expires on: / /

**Operator:**

Phone #: 6129648376
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.

**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.

LIKE STATED ABOVE. RAW EGGS WERE STORED ABOVE MILK AND JUICE IN THE UPRIGHT COOLER. STORE ALL FOODS BY COOK TEMPERATURE.

*Comply By: 10/17/22*

**3-500D Microbial Control: disposition of food**

3-501.18A ** Priority 1 **

MN Rule 4626.0405A Discard all TCS food prepared in the establishment or opened commercially packaged food when the time exceeds 7 days from the preparation or opening date or if the container or package is not marked.

UPRIGHT COOLER: DISCARD COTTO SALAMI LUNCHMEAT DATED 10/4 AND HAM LUNCHMEAT DATED 10/8.

*Corrected on Site*

**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.

PROVIDE A THIN TIPPED THERMOMETER (W/ THIN TAPERED END) LIKE STATED ABOVE FOR THIN FOODS LIKE CHICKEN NUGGETS AND PATTIES. CURRENTLY THERE IS ONLY A REGULAR METAL STEM THERMOMETER IN THE KITCHEN WHICH IS ONLY APPROVED FOR USE IN THICKER FOODS LIKE SOUP.

*Comply By: 10/24/22*

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

3-302.12

MN Rule 4626.0240 Properly label all working containers holding food or food ingredients that are removed from orginal packages with the common name of the food. Label the food in English and any other languages used by employees who handle food.

THE FLOUR AND SUGAR CONTAINERS WERE NOT LABELED AT TIME OF INSPECTION.

*Comply By: 10/17/22*

**4-100 Equipment Construction Materials**

4-101.11BCDE

MN Rule 4626.0450BCDE Remove all multi-use equipment, utensils, and food storage containers that are not durable, corrosion-resistant, nonabsorbent, smooth, easily cleanable, resistant to pitting, chipping, scratching or not able to withstand repeated warewashing.

AT TIME OF INSPECTION SOUR CREAM AND ICE CREAM CONTAINERS WERE BEING RE-USED TO STORE FOOD IN. REMOVE ALL SINGLE-SERVICE FOOD CONTAINERS AND PROVIDE APPROVED CONTAINERS TO REPLACE THEM.

*Comply By: 10/19/22*

**4-100 Equipment Construction Materials**

4-101.19

MN Rule 4626.0495 Remove non-food-contact surfaces of equipment that are exposed to splash, spillage, or other food soiling, or that require frequent cleaning, that are not constructed of a corrosion-resistant, non-absorbent, and smooth material.

REMOVE THE TOWEL THAT IS STORED ON THE DRY STORAGE RACK UNDER DISHES. PROVIDE A SMOOTH AND EASILY CLEANABLE SURFACE IF NEEDED UNDER THE DISHES.

*Comply By: 10/17/22*

**4-200 Equipment Design and Construction**

4-201.11AMN

MN Rule 4626.0506A Provide or replace food service equipment with equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

THE FOLLOWING ITEMS ARE NOT COMMERCIAL AND MUST BE REMOVED FROM THE ESTABLISHMENT: POWER XL AIR FRYER AND FOOD SAVER.

*Comply By: 10/17/22*

**8-200 Plan Submission and Approval**

8-201.13B

MN Rule 4626.1730B Submit a HACCP plan to the regulatory authority before engaging in reduced oxygen packaging without a variance.

LIKE STATED ABOVE IF THE KITCHEN STAFF CHOOSE TO DO REDUCED OXYGEN PACKAGING (R.O.P). OTHERWISE, REMOVE THE REDUCED OXYGEN PACKAGING DEVICE

# Food and Beverage Establishment Inspection Report



(FOOD SAVER) FROM THE ESTABLISHMENT IF THE KITCHEN STAFF DO NOT WANT TO SUBMIT A HACCP PLAN TO DO R.O.P.

*Comply By: 10/18/22*

**Surface and Equipment Sanitizers**

Chlorine: > 200PPM at  Degrees Fahrenheit
Location: SANITIZER BUCKET
Violation Issued: No

Hot Water: =  at 162 Degrees Fahrenheit
Location: DISHWASHER FINAL RINSE CYCLE
Violation Issued: No

**Food and Equipment Temperatures**

Process/Item: Upright Cooler
Temperature: 38 Degrees Fahrenheit  - Location: COTTO SALAMI
Violation Issued: No

| Total Orders In This Report | Priority 1 | Priority 2 | Priority 3 |
|---|---|---|---|
| | 2 | 1 | 5 |

**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 7930221167 of 10/17/22.

Certified Food Protection Manager: Amanda R. Block

Certification Number: 111427 Expires: 06/02/25

**Inspection report reviewed with person in charge and emailed.**

Signed:_____
Establishment Representative

Signed: Tina Remmele
Tina Remmele, R.S.
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Report #: 7930221167

# Food Establishment Inspection Report

DEPARTMENT OF HEALTH

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

| | | | |
|---|---|---|---|
| No. of RF/PHI Categories Out | 2 | Date | 10/17/22 |
| No. of Repeat RF/PHI Categories Out | 0 | Time In | 11:45:04 |
| Legal Authority MN Rules Chapter 4626 | | Time Out | |

| | Address | City/State | Zip Code | Telephone |
|---|---|---|---|---|
| The Watkins House | 341 4th Street North | Watkins, MN | 55389 | 6129648376 |

| License/Permit # | Permit Holder | Purpose of Inspection | Est Type | Risk Category |
|---|---|---|---|---|
| 0038453 | | Full | | |

## FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item. Mark "X" in appropriate box for COS and/or R.

**IN=** in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

| Compliance Status | | COS | R |
|---|---|---|---|
| **Supervision** | | | |
| 1 IN OUT | PIC knowledgeable; duties & oversight | | |
| 2 IN OUT N/A | Certified food protection manager, duties | | |
| **Employee Health** | | | |
| 3 IN OUT | Mgmt/Staff;knowledge,responsibilities&reporting | | |
| 4 IN OUT | Proper use of reporting, restriction & exclusion | | |
| 5 IN OUT | Procedures for responding to vomiting & diarrheal events | | |
| **Good Hygenic Practices** | | | |
| 6 IN OUT N/O | Proper eating, tasting, drinking, or tobacco use | | |
| 7 IN OUT N/O | No discharge from eyes, nose, & mouth | | |
| **Preventing Contamination by Hands** | | | |
| 8 IN OUT N/O | Hands clean & properly washed | | |
| 9 IN OUT N/A N/O | No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed | | |
| 10 IN OUT | Adequate handwashing sinks supplied/accessible | | |
| **Approved Source** | | | |
| 11 IN OUT | Food obtained from approved source | | |
| 12 IN OUT N/A N/O | Food received at proper temperature | | |
| 13 IN OUT | Food in good condition, safe, & unadulterated | | |
| 14 IN OUT N/A N/O | Required records available; shellstock tags, parasite destruction | | |
| **Protection from Contamination** | | | |
| 15 IN OUT N/A N/O | Food separated and protected | | |
| 16 IN OUT N/A | Food contact surfaces: cleaned & sanitized | | |
| 17 IN OUT | Proper disposition of returned, previously served, reconditioned, & unsafe food | | |

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

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

## GOOD RETAIL PRACTICES

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

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

| | | | COS | R |
|---|---|---|---|---|
| **Safe Food and Water** | | | | |
| 30 | IN OUT N/A | Pasteurized eggs used where required | | |
| 31 | | Water & ice obtained from an approved source | | |
| 32 | IN OUT N/A | Variance obtained for specialized processing methods | | |
| **Food Temperature Control** | | | | |
| 33 | | Proper cooling methods used; adequate equipment for temperature control | | |
| 34 | IN OUT N/A N/O | Plant food properly cooked for hot holding | | |
| 35 | IN OUT N/A N/O | Approved thawing methods used | | |
| 36 | X | Thermometers provided & accurate | | |
| **Food Identification** | | | | |
| 37 | X | Food properly labled; original container | | |
| **Prevention of Food Contamination** | | | | |
| 38 | | Insects, rodents, & animals not present | | |
| 39 | | Contamination prevented during food prep, storage & display | | |
| 40 | | Personal cleanliness | | |
| 41 | | Wiping cloths: properly used & stored | | |
| 42 | | Washing fruits & vegetables | | |

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

**Food Recalls:**

**Person in Charge (Signature)** **Date:** 10/17/22

Inspector (Signature) Tina Remmle