Electronically Delivered

April 24, 2024

Licensee
French Meadow Place
105 Plum Run Road
Le Sueur, MN 56058

RE: Project Number(s) SL30477016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 10, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the

resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS

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

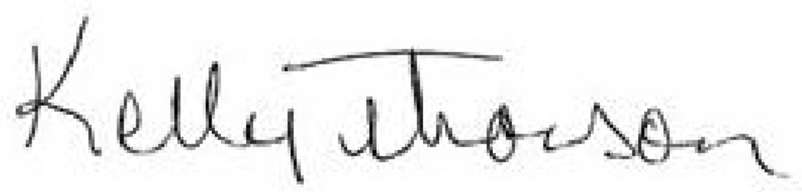
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

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

If you have any questions, please contact me.

Sincerely,



Kelly Thorson, Supervisor
State Evaluation Team
Email: kelly.thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30477	A. BUILDING: _____ B. WING _____	04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRENCH MEADOW PLACE	105 PLUM RUN ROAD LE SUEUR, MN 56058

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30477016 On April 8, 2024, through April 10, 2024, 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 29 resident(s); all receiving 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. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that:	0 470		

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

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0 470	Continued From page 2 problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: The licensee held an assisted living with dementia care license and was licensed for a capacity of 37 residents and had a current census of 29 residents. On April 8, 2024, at 12:30 p.m., the surveyor observed the common areas of the assisted living facility and the locked dementia care unit and noted the lack of a 24-hour staffing schedule in both areas. On April 10, 2024, at 12:05 p.m., community director (CD)-E stated the staffing schedule was only posted in the employee area. It had been in the main entry, but the walls were going to be painted and it was never moved back. The licensee's Staffing and Scheduling-Minnesota policy dated January 31, 2024, indicated, the daily work schedule must be posted, after redacting direct-care staff members' resident assignments, at the beginning of each work shift in a central location in each building of a facility or campus, accessible to staff, residents, volunteers, and the public. The facility shall not disclose any information that is protected by law from public disclosure. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		

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0 480	Continued From page 3	0 480		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated April 9, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must	0 650		

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0 650	Continued From page 4 include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure employee records contained the required content for one of two employees (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	0 650		

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0 650	Continued From page 5 ULP-C began employment on May 5, 2022. On April 9, 2024, at 7:51 a.m., surveyor observed ULP-C administer medications and serve breakfast. ULP-C's employee record lacked the following: - documentation of a current annual performance review that identified areas of improvement needed and training needs. On April 10, 2024, at 11:00 a.m., community director (CD)-E stated ULP-C's review was missed. The licensee's Employee Evaluation policy dated December 9, 2023, indicated all staff of [the facility] will be given an employee evaluation at least annually. The licensee's Employee Records policy dated May 6, 2022, indicated employees' records for each person will include documentation of annual performance review that identify areas of improvement needed and training needs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies	0 680		

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

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0 680	Continued From page 7 The licensee's EPP dated August 1, 2021, lacked documentation including all the required elements of: -annual review -rosters of employees, residents, volunteers -policies and procedures for volunteers -names and contacts for staff, entities providing services under agreement, residents', physicians, other facilities, volunteers -policies/procedures for system to track the location of on-duty staff and sheltered residents On April 10, 2024, at 10:00 a.m., community director (CD-E) stated the EPP is reviewed at monthly quality assurance meetings, but staff did not document that this was done. CD-E stated they do not have rosters for employees, residents, or volunteers and they do not have policies and procedures for volunteers. CD-E stated they do not have names and contacts for staff, entities providing services under agreement, residents, physicians, other facilities, or volunteers and they do not have policies or procedures for a system to track the location of on-duty staff and sheltered residents. CD-E further stated she is new to her position and is currently updating the EPP to include the required information. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated [the facility] emergency preparedness plan will include all required elements of appendix Z. The plan will be in writing and reviewed annually. The plan is based on our assisted living-based and community-based risk assessments, utilizing an all-hazards approach. Key elements of the plan include four primary components:	0 680		

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0 680	Continued From page 8 1. Risk assessment and planning 2. Policies and procedures 3. A communication plan 4. Staff training and exercises/drills No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure personal health and medical information was kept private for all five residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents).	0 700		

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0 700	Continued From page 9 These finding include: On April 9, 2024, at 10:57 a.m. the surveyor observed unlicensed personnel (ULP)-D prepare to perform a blood glucose reading and administer insulin. ULP-D walked to the medication cart on the first-floor hallway. The computer was sitting on the medication cart open and unsecured. ULP-D left to go find the resident and left the computer open and unsecured. ULP-D returned to the medication cart, gathered supplies, and went to the resident's room again leaving the computer open and unsecured. On April 9, 2024, at 11:01 a.m., ULP-D stated she usually leaves the computer unlocked, but sometimes closes the cover. On April 9, 2024, at 2:07 p.m., clinical nurse supervisor (CNS)-B stated staff are trained to close computers when walking away from them, staff should not be leaving them open. CNS-B further stated nursing does regular audits of computers and rarely sees them open. The licensee's Resident Record-Confidentiality policy dated February 4, 2023, indicated resident records will be kept confidential and locked in a secure area where only authorized staff have access to. All staff are responsible to make sure confidentiality is maintained for all resident records and information. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700		

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01890	Continued From page 10	01890		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to keep medications in their original containers bearing the original prescription label and failed to ensure medications included the expiration date for time sensitive medications. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: On April 9, 2024, at 8:30 a.m., the surveyor, along with unlicensed personnel (ULP)-C observed the medication cart in the memory care unit and found the following: -two insulin pens (one Lantus Solostar and one Humalog Kwik pen) without pharmacy labels and not labeled with open dates On April 9, 2024, at 8:35 a.m., ULP-C stated	01890		

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01890	Continued From page 11 insulin pens should be labeled with an opened date, that was how they were trained and was not sure why it was not done. ULP further stated there is only one person on the memory care unit who uses insulin, so he knew who the insulin belonged to without the label. On April 10, 2024, at 2:10 p.m., clinical nurse supervisor (CNS)-B stated staff should be dating insulin pens when they are opened and if they see an insulin pen without a date on it, they dispose of it and start a new pen. Pharmacy does not put labels on the insulin pens so someone should be writing the residents name on the insulin pens when they take them out of the box. The licensee's Insulin policy dated January 31, 2024, indicated when administering insulin compare the information of the MAR (medication administration record) with the label on the medication container. The following information should be in all the places: resident name, name of the medication, the strength and dose of the medication, the route, the time that the medication is to be given, any special instructions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen 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	01940		

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01940	Continued From page 12 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: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for three of three residents (R2, R3, R4). 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	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30477	A. BUILDING: _____ B. WING _____	04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRENCH MEADOW PLACE	105 PLUM RUN ROAD LE SUEUR, MN 56058

(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 13 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: R2 R2 had diagnoses to include type II diabetes mellitus. R2's provider orders dated March 18, 2024, indicated R2 should test blood glucose prior to meals and before bed. R2's treatment administration record for April 2024 indicated R2 gets their blood glucose recorded four times daily. R2's service plan dated January 18, 2024, did not include blood glucose monitoring. R3 R3 had diagnoses to include esophageal obstruction. R3's provider orders dated December 18, 2023, indicated blood glucose monitoring and the use of compression stockings. R3's Service Recap Summary document for April indicated R3 received blood glucose monitoring twice daily, but did not indicate assistance with compression stockings. R3's service plan dated April 8, 2024, did not include assistance with compression stockings. R3's Treatment and Therapy Plan dated April 9, 2024, lacked the following:	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30477	A. BUILDING: _____ B. WING _____	04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRENCH MEADOW PLACE	105 PLUM RUN ROAD LE SUEUR, MN 56058

(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 14 - a statement of the type of services that will be provided -documentation of specific resident instructions relating to the treatments or therapy administration -procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and -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. R4 R4 had diagnoses to include benign prostatic hyperplasia. R4's service plan dated February 23, 2024, indicated R4 received catheter care from unlicensed staff. R4's Treatment and Therapy plan dated April 9, 2024, lacked the following: - a statement of the type of services that will be provided -documentation of specific resident instructions relating to the treatments or therapy administration -procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and -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	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30477	A. BUILDING: _____ B. WING _____	04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRENCH MEADOW PLACE	105 PLUM RUN ROAD LE SUEUR, MN 56058

(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 15 complications or adverse reactions On April 10, 2024, at 12:40 p.m. corporate director of clinical (CDOC)-A stated treatment plans are completed in the assessment, but is not sure why they are not showing on the treatment plan. On April 10, 2024, at 1:20 p.m., clinical nurse supervisor (CNS)-B stated she was aware of the treatment plan requirements. The licensee's Assessments, Reviews & Monitoring policy dated August 1, 2022, indicated the initial nursing assessment or reassessment must include all the elements of the uniform assessment tool as required, conducted in person, be in writing, dated, and signed by the registered nurse who conducted the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		

Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *04/09/24*
Time: 08:34:21
Report: 8044241085

Food and Beverage Establishment Inspection Report

Location:
French Meadow Place
105 Plum Run Road
Le Sueur, MN56058
Le Sueur County, 40

Establishment Info:
ID #: 0037531
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7633771800
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 previously issued on 04/09/24 have NOT been corrected.

5-200C Plumbing: Maintenance, fixture location

5-205.13 ***** Priority 2 *****

MN Rule 4626.1120 Inspect, test and maintain water treatment and backflow prevention devices according to the manufacturer's instructions and as necessary to prevent device failure. The person in charge must maintain records of inspection and service of water treatment and backflow prevention devices.

RPZ backflow prevention device for boiler missing inspection tag.
Issued on: 04/09/24 *Comply By: 04/23/24*

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

Chipping paint on walls throughout kitchen.
Issued on: 04/09/24 *Comply By: 06/09/24*

6-300 Physical Facility Numbers and Capacities

6-301.14A

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

Originally issued in November 2022.

Sign not posted at handwashing sink in memory care serving area.
Issued on: 04/09/24 *Comply By: 04/09/24*

The following orders were issued during this inspection.

5-200C Plumbing: Maintenance, fixture location

5-205.13 ***** Priority 2 *****

MN Rule 4626.1120 Inspect, test and maintain water treatment and backflow prevention devices according to the manufacturer's instructions and as necessary to prevent device failure. The person in charge must maintain records of inspection and service of water treatment and backflow prevention devices.

RPZ backflow prevention device for boiler missing inspection tag.

Comply By: 04/23/24

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

Chipping paint on walls throughout kitchen.

Comply By: 06/09/24

6-300 Physical Facility Numbers and Capacities

6-301.14A

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

Originally issued in November 2022.

Sign not posted at handwashing sink in memory care serving area.

Comply By: 04/09/24

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 40.1 Degrees Fahrenheit - Location: Sour cream in upright
Violation Issued: No

Process/Item: Cold Holding
Temperature: 41.2 Degrees Fahrenheit - Location: Ground beef in upright
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40.0 Degrees Fahrenheit - Location: Upright
Violation Issued: No

Process/Item: Cold Holding
Temperature: 38.4 Degrees Fahrenheit - Location: Milk in memory care fridge
Violation Issued: No

Type: Full
Date: *04/09/24*
Time: 08:34:21
Report: 8044241085
French Meadow Place

Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding
Temperature: 39.0 Degrees Fahrenheit - Location: Memory care fridge
Violation Issued: No

Process/Item: Hot Holding
Temperature: 169.5 Degrees Fahrenheit - Location: Scrambled eggs
Violation Issued: No

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

HRD inspection conducted with nurse evaluator Wendy Robarge. Inspection report reviewed on site with Tammy Roemhildt

Establishment Info: Report emailed to Nina at nflannery@cornerstonemgmt.com

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 8044241085 of 04/09/24.

Certified Food Protection Manager: Alisa B. Beneke

Certification Number: FM85127 Expires: 07/26/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Inspector signed for Tammy

Signed: _____
Michael DeMars, RS
Public Health Sanitarian III
Rochester District Office
507-216-1096
michael.demars@state.mn.us