Electronically Delivered

January 18, 2024

Licensee
Indigo Healthcare Services, LLC
1161 Cherry Lane Northeast
Columbia Heights, MN 55421

RE: Project Number(s) SL35843015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 19, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

PMB

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 35843 | A. BUILDING: _____ B. WING _____ | 12/19/2023 |

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| 0 000 | Initial Comments<br><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>SL35843015-0<br><br>On December 18, 2023, through December 19, 2023, 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 five residents receiving services under the Assisted Living license. | 0 000 | Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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<br><br>(13) offer to provide or make available at least the | 0 480 | | |

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| 0 480 | Continued From page 1<br><br>following services to residents:<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 document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated December 19, 2023, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.<br><br>TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates. | 0 480 | | |
| 0 680 SS=F | 144G.42 Subd. 10 Disaster planning and emergency preparedness<br><br>(a) The facility must meet the following requirements:<br>(1) have a written emergency disaster plan that | 0 680 | | |

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| 0 680 | Continued From page 2<br><br>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 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 observation, interview, and record review, the licensee failed to prominently post an emergency disaster plan. This had the potential to affect all residents, staff, and visitors.<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 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). | 0 680 | | |

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| 0 680 | Continued From page 3<br>The findings include:<br><br>On December 18, 2023, at 11:30 a.m., the surveyor toured the facility and observed the facility did not have an emergency disaster plan posted prominently.<br><br>On December 18, 2023, at 11:45 a.m., the surveyor asked licensed assisted living director (LALD)-A where the emergency plan was located. LALD-A stated the emergency plan was kept on the computer and in a binder in LALD-A's office. LALD-A stated the office is locked at all times; however, staff have a key to access the office.<br><br>On December 19, 2023, at 11:10 a.m., LALD-A confirmed the emergency disaster plan was not posted and stated he was unaware of the requirement to post the Emergency Preparedness plan prominently.<br><br>The licensee's emergency preparedness plan policy dated August 1, 2021, indicated the emergency disaster plan would be prominently posted on each floor of the facility.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 680 | | |
| 0 800 SS=F | 144G.45 Subd. 2 (a) (4) Fire protection and physical environment<br><br>(4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the | 0 800 | | |

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| 0 800 | Continued From page 4<br>residents in accordance with a maintenance and repair program.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors.<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 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>On a facility tour on December 19, 2023, at 9:45 a.m., with licensed assisted living director (LALD)-A, the surveyor made the following observations of facility hazards and disrepair:<br><br>The patio doors leading to the decks on the back side of the facility were identified on the fire safety and evacuation plan (FSEP) floor plan as exits. The patio doors led to the exterior decks that did not have a stairway leading to the ground and to the public way (sidewalk, driveway, or street at front of facility) for exiting in the event of a fire or similar emergency. Only exit doors that lead from the facility interior and are maintained to the public way shall be identified as exits on the | 0 800 | | |

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| 0 800 | Continued From page 5<br>FSEP floor plan.<br><br>During a facility tour on December 19, 2023, at 9:45 a.m., LALD-A verified the patio doors leading to the exterior decks with no exterior exit path maintained to the public way, are marked as exits on the FSEP floor plan.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 800 | | |
| 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;<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 | 0 810 | | |

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| 0 810 | Continued From page 6<br><br>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 observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content, make the plan readily available, provide required training and drills. This had the potential to directly affect all residents, staff, and visitors.<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 potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>On December 19, 2023, at 10:00 a.m., licensed assisted living director (LALD)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility.<br><br>FIRE SAFETY AND EVACUATION PLAN<br>The licensee FSEP dated August 1, 2021, failed to include the following:<br><br>The FSEP did not identify specific fire protection | 0 810 | | |

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| 0 810 | Continued From page 7<br><br>actions for residents evident by the resident actions required not being included in writing in the FSEP.<br><br>The FSEP included standard resident evacuation procedures, but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included blank documents that had not been filled out with each residents evacuation needs and kept with the plan for reference in the event of a fire or similar emergency.<br><br>During an interview on December 19, 2023, at 10:00 a.m., LALD-A stated the completed forms of unique and unusual needs of each resident for evacuation were not kept with the FSEP for reference in the event of a fire or similar emergency.<br><br>TRAINING<br>Record review indicated the licensee failed to provided evacuation training to residents at least once per year as evident by no documentation provided indicating residents have received evacuation training.<br><br>Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and/or at least twice per year as evident by providing training records based on general emergency preparedness and not training specific to the facility fire safety and evacuation policy and procedures.<br><br>During an interview on December 19, 2023, at 10:00 a.m., LALD-A stated the fire safety and evacuation training policy and procedures training | 0 810 | | |

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| 0 810 | Continued From page 8<br><br>for employees was completed with the emergency preparedness training and test but it was not documented that way on the training form.<br><br>DRILLS<br>Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month as evident by providing documentation fire drills were completed as follows:<br><br>March 22, 2023, at 5:30 p.m.<br>August 17, 2023, at 10:00 a.m. and 4:00 p.m.<br>August 18, 2023, at 6:00 a.m.<br>November 18, 2023, 1st shift, 2nd shift, and 3rd shift<br><br>During an interview on December 19, 2023, at 10:00 a.m., LALD-A stated they were not clear on the sequence required for the fire drills and will adjust the sequence to meet the requirements.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 0 810 | | |
| 01620 SS=F | 144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring<br><br>(c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment.<br>(d) For residents only receiving assisted living services specified in section 144G.08, subdivision | 01620 | | |

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| 01620 | Continued From page 9<br><br>9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review.<br>(e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.<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) completed a comprehensive reassessment to include an assessment of current smoking status for five of five residents (R6, R1, R3, R5, R4).<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 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>R6<br>R6's diagnoses included Asperger Syndrome, attention deficit disorder (ADHD) and suicidal | 01620 | | |

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| 01620 | Continued From page 10<br>ideation.<br><br>On December 18, 2023, at 11:30 a.m., the surveyor observed multiple lighters and cigarettes in R6's room.<br><br>On December 19, 2023, at 10:54 a.m., licensed assisted living director (LALD)-A stated R6 smoked daily.<br><br>R1<br>R1's diagnoses included traumatic brain injury (TBI), post-traumatic stress syndrome (PTSD) and major depressive disorder.<br><br>R1's service plan dated May 24, 2023, indicated the resident received services to include medication administration, cooking supervision, behavior monitoring, weekly blood pressure checks, housekeeping and laundry.<br><br>R1's initial assessment dated May 24, 2023, indicated R1 had a history of seizures, experienced chronic pain, had a history of non-compliance with medications, left home frequently, had a history of making threats to police, was found manufacturing a gun in his room and had a suicidal ideation event on November 17, 2023. The assessment indicated R1 smoked cigarettes daily. R1's assessment did not address the safety, risks and management of R1's cigarettes or lighter usage.<br><br>On December 19, 2023, at 10:20 a.m., the surveyor observed R1 return to the kitchen from smoking outside with co-residents.<br><br>R3<br>R3's diagnoses included schizophrenia, agoraphobia (anxiety disorder) and human | 01620 | | |

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| 01620 | Continued From page 11<br>immunodeficiency virus (HIV).<br><br>On December 19, 2023, at 10:25 a.m., the surveyor observed R3 return to the kitchen from smoking outside with co-residents.<br><br>R5<br>R5's diagnoses included Asperger Syndrome (developmental disorder) and attention deficit disorder (ADHD).<br><br>On December 19, 2023, at 10:25 a.m., the surveyor observed R5 return to the kitchen from smoking outside with co-residents.<br><br>R4<br>R4's diagnoses included schizophrenia, bipolar and substance abuse disorders.<br><br>On December 19, 2023, at 10:54 a.m., LALD-A confirmed R4 smoked daily.<br><br>On December 19, 2023, at 10:54 a.m., the surveyor interviewed LALD-A and clinical nurse supervisor (CNS)-D. LALD-A stated all residents were daily smokers. CNS-D stated resident assessments lacked assessment of the safety, risks and/or abilities of R6, R1, R3, R5 and R4 to manage cigarettes or lighters. Additionally, LALD-A stated all assessments were the same template and did not include an area to address smoking safety. CNS-D stated she was unaware of the requirement to address smoking safety in the assessment.<br><br>The licensee's Comprehensive Nursing Assessment policy dated August 1, 2021, indicated the registered nurse (RN) would conduct a comprehensive assessment with lifestyle preferences to include smoking and | 01620 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 35843 | A. BUILDING: _____ B. WING _____ | 12/19/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| INDIGO HEALTHCARE SERVICES LLC | 1161 CHERRY LANE NE COLUMBIA HEIGHTS, MN 55421 |

| (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 |
|---|---|---|---|---|
| 01620 | Continued From page 12<br>safety factors.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 01620 | | |
| 01750 SS=F | 144G.71 Subd. 7 Delegation of medication administration<br><br>When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has:<br>(1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures;<br>(2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and<br>(3) communicated with the unlicensed personnel about the individual needs of the resident.<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 documented resident-specific instructions for medications for one of five residents (R1) whose medication administration was delegated to unlicensed personnel.<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 widespread scope (when problems are pervasive or represent a systemic | 01750 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 35843 | A. BUILDING: _____ B. WING _____ | 12/19/2023 |

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|---|---|
| INDIGO HEALTHCARE SERVICES LLC | 1161 CHERRY LANE NE COLUMBIA HEIGHTS, MN 55421 |

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|---|---|---|---|---|
| 01750 | Continued From page 13<br><br>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<br>R1's electronic medication administration record (EMAR) lacked specific, written instructions regarding the administration of scheduled medications.<br><br>R1's diagnoses included traumatic brain injury (TBI), post-traumatic stress syndrome (PTSD) and major depressive disorder.<br><br>R1's service plan dated May 24, 2023, indicated the resident received services to include medication administration.<br><br>On December 18, 2023, at 1:30 p.m., the surveyor observed unlicensed personnel (ULP)-B administer R1's afternoon medications. ULP-B opened a locked cupboard, removed the med caddie (a multicompartment pill storage container labeled with each day of the week and time), poured the medications into a medication cup and counted the number of pills. ULP-B confirmed eight pills were in the medication cup and verified a total of eight medication pills in the EMAR. The surveyor asked ULP-B to show the surveyor where in the EMAR it provided a description of the pills for verification. ULP-B was unable to find a description of the medication for verification purposes. Additionally, ULP-B stated staff counted the number of pills against the total number of medication pills to be administered as the medication verification process.<br><br>R1's Medication Administration Record, dated November 1, 2023, through November 30, 2023, | 01750 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 35843 | A. BUILDING: _____ B. WING _____ | 12/19/2023 |

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|---|---|
| INDIGO HEALTHCARE SERVICES LLC | 1161 CHERRY LANE NE COLUMBIA HEIGHTS, MN 55421 |

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|---|---|---|---|---|
| 01750 | Continued From page 14<br><br>included:<br>- fluoxetine 40 milligrams (mg) two capsules one time daily for depression;<br>- hydroxyzine pamoate 50 mg two capsules twice daily for anxiety and irritation;<br>- olanzapine 5 mg twice daily for schizophrenia;<br>- metformin 500 mg four tablets once daily for diabetes;<br>- aristada 882/3.2 milliliter (ml) injection every four weeks for schizophrenia;<br>- divalproex 500 mg two tablets three times daily for seizures; and<br>- quetiapine 50 mg and 100 mg three times daily for schizophrenia.<br><br>The licensee failed to provide resident-specific instructions pertaining to the use of a med caddie and a description of pills for staff to verify in the EMAR.<br><br>On December 19, 2023, at 9:50 a.m., licensed assisted living director (LALD)-A confirmed there were no specific, written instructions for R1's medications or pill identifiers. LALD-A confirmed all residents received medications from a med caddie set up by LALD-A, who is a licensed pharmacist, and all resident EMAR's would lack specific instructions and/or pill identifiers. Additionally, LALD-A stated he didn't feel ULP's needed to know what was in the caddie as they were to follow the pill count. LALD-A stated he was unaware of the requirement for specific instructions or a pill identifier.<br><br>The licensee's Medication Administration policy dated August 1, 2021, indicated a registered nurse (RN) may delegate medication administration to an unlicensed staff member after the RN has prepared written instructions for the ULP. Additionally, the policy indicated all staff | 01750 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 35843 | A. BUILDING: _____ B. WING _____ | 12/19/2023 |

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| INDIGO HEALTHCARE SERVICES LLC | 1161 CHERRY LANE NE COLUMBIA HEIGHTS, MN 55421 |

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|---|---|---|---|---|
| 01750 | Continued From page 15<br>with responsibility for medication administration would have access to information about the medication being administered.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01750 | | |

Minnesota Department of Health
Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
6512014500

Type: Full
Date: *12/19/23*
Time: 10:25:50
Report: 1047231104

# Food and Beverage Establishment Inspection Report



**Location:**
Indigo Healthcare Services LLC
1161 Cherry Lane Ne
Columbia Heights, MN55421
Anoka County, 02

**Establishment Info:**
ID #: 0038923
Risk:
Announced Inspection: No

**License Categories:**

Expires on: / /

**Operator:**

Phone #: 7633900771
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.

**3-500B Microbial Control: hot and cold holding**

***3-501.16A2*** ***** Priority 1 *****

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

TEMPERATURE IN REFRIGERATOR #2 (SECOND HALF OF DUPLEX) WAS NOT HOLDING TEMPERATURES AT OR BELOW 41F. STAFF STATED HE WILL MONITOR FRIDGE. FRIDGE #1 CAN BE USED TO STORE FOOD UNTIL OTHER IS HOLDING TEMPERATURE.

*Comply By: 12/19/23*

**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.

NO SMALL PROBE THERMOMETER AVAILABLE AT FACILITY. OBTAIN & USE SMALL PROBE THERMOMETER TO MEASURE FINAL COOKING TEMPERATURES.

*Comply By: 12/20/23*

**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.

SEAL ON BOTTOM OF REFRIGERATOR #2 DOOR IS BROKEN & HAS PEELED AWAY FROM DOOR. REPAIR OR REPLACE.

*Comply By: 01/02/24*

Type: Full
Date: *12/19/23*
Time: 10:25:50
Report: 1047231104
Indigo Healthcare Services LLC

# Food and Beverage Establishment Inspection Report

**Food and Equipment Temperatures**

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: Refrigerator #1- turkey
Violation Issued: No

Process/Item: Cold Holding
Temperature: 46 Degrees Fahrenheit - Location: Refrigerator #2- butter
Violation Issued: Yes

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

Inspection conducted with operator & MDH Nurse Evaluator K. Barnhart.

The establishment has two residential kitchens (duplex set up) and serves food that is prepared that day. Currently staff prepares food for one resident. The kitchens have wood cabinets, laminate floor, painted walls, solid counter top, and a
painted ceiling.

A two basin sink is located in the kitchen. One sink basin is designated for hand washing.

A residential dish machine is located in the kitchen. Facility has a thermometer to measure dish machine temperature.

Discussed hand washing, ware washing, staff illness policy, temperature control, final cook temperatures,cleaning, serving highly susceptible populations, and food handling procedures.

**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 1047231104 of 12/19/23.

Certified Food Protection Manager: Messiah K Moore

Certification Number: FM114863 Expires: 12/13/25

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

Signed: _____
Messiah Moore
Director

Signed: _____
Holly Sievers
Public Health Sanitarian 2
Metro Office
6512015946
Holly.Sievers@state.mn.us