Electronically Delivered
May 17, 2023

Licensee
Springbrook Village of La Crescent
1384 County Road 25
La Crescent, MN 55947

RE: Project Number(s) SL33651015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 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.

The 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. 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 . . ."

IMPOSITION OF FINES
In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

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

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

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00

The total amount you are assessed is $500.00. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

Please address your cover letter for reconsideration requests to:

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

REQUESTING A HEARING

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

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,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 651-281-9796

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33651	A. BUILDING: _____ B. WING _____	04/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGBROOK VILLAGE LACRESCENT	1384 COUNTY ROAD 25 LA CRESCENT, MN 55947

(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: SL33651015 On April 17, 2023, through April 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 sixty-eight (68) active residents receiving services under the Assisted Living 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 and interview, the licensee failed to ensure a staffing plan was developed and a daily staff schedule was posted as required, potentially affecting all licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 470		

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0 470	Continued From page 2 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During facility tour on April 17, 2023, at 10:30 a.m., the surveyor did not observe a posted staff schedule developed by the clinical nurse supervisor in any area of the facility to: - include direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked; - identify the direct-care staff member's resident assignments or work location; and - be posted after redacting direct-care staff member's resident assignments, at the beginning of each work shift in a central location in each building. On April 17, 2023, at 10:48 a.m., registered nurse (RN)-A stated there was a staffing schedule available but was unaware there was not one posted. RN-A also stated she was not aware she needed to develop a staffing plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules,	0 480		

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0 480	Continued From page 3 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 had the potential to affect all residents in the Assisted Living Dementia Care facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report, dated April 17, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and	0 510		

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0 510	Continued From page 4 Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure infection control standards were followed for one of two unlicensed personnel ((ULP)-B) providing personal cares. 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 client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On April 17, 2023, at 11:25 a.m., ULP-B wore gloves while distributing plates of food to residents during the lunch service. ULP-B took plates that she had placed food items onto from the food warmer used to keep food warm and served residents sitting at the dining tables. During this time, ULP-B conversed with staff and residents. ULP-B walked into the kitchen while still wearing gloves that she had used to deliver meal plates and raised her hand to nose and rubbed nose using the bottom portion of the right glove. ULP-B did not remove her gloves or wash	0 510		

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0 510	Continued From page 5	0 510		

her hands after rubbing her nose and proceeded to place food items onto a plate from the food warmer. ULP-B then brought the plate of food to a resident sitting at a table in the dining room. ULP-B continued to wear the same gloves and proceeded to return to the kitchen to place food onto plates from the food warmer. ULP-B did not remove gloves during this time nor did ULP-B wash her hands.

During interview on April 17, 2023, at 11:55 a.m., ULP-B stated she had received annual education recently on the use of wearing gloves and hand washing. When asked if she had ever been audited for glove use or hand washing, ULP-B stated she had not.

During interview on April 18, 2023, at 11:30 a.m., surveyor explained to registered nurse (RN)-A and licensed assisting living director (LALD)-C what observations were seen with ULP-B. RN-A stated staff were recently re-educated on hand washing and glove wearing, and ULP-B would need to be re-educated.

The licensee's Handwashing and Sanitizing policy dated January 1, 2017, indicated hands must be washed thoroughly with antimicrobial soap and water, including but are not limited to before and after assisting residents or staff with any contact with bodily fluids, blood, mucous membranes, non-intact skin, or any other contaminated surfaces and before and after gloving.

The licensee's Personal Protective Equipment policy, undated, indicated gloves are single-use items and should be used for invasive procedures including contact with sterile sites, non-intact skin, or mucous membranes, and for activities that have been assessed as carrying a risk of

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0 510	Continued From page 6 exposure to blood, body fluid or infectious respired aerosols or droplets. They must be put on immediately before an episode of client contact or treatment. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) Days	0 510		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in and maintain documentation of ongoing quality management activities relevant to the size and services provided by the assisted living provider. 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	0 580		

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0 580	Continued From page 7 cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During an interview on April 17, 2023, at 10:55 a.m., registered nurse (RN)-A stated the licensee conducted a daily meeting with management to discuss any of the licensee's issues. RN-A stated there was not a specific meeting to evaluate the quality of care by reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. RN-A also stated the licensee did not keep documentation of the daily staff meetings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center	0 640		

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0 640	Continued From page 8 to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to support protection and safety by not posting information to contact 911 emergency number in common areas and near telephones provided by the assisted living dementia care facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During a building tour on April 17, 2023, at approximately 11:45 a.m., the surveyor noted the facility's common areas had no posting of the 911 emergency number. During an interview on April 18, 2023, at 11:35 a.m., registered nurse (RN)-A stated she believed the information was posted and was not aware there was no information about 911 information. The licensee's Emergency/911 policy dated August 1, 2021, identified the procedure to contact 911 emergency services in the event of an emergency.	0 640		

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0 640	Continued From page 9 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
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 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 interview and record review, the licensee failed to ensure the employee record contained the required content for one of one employee (registered nurse (RN)-A). This practice resulted in a level two violation (a	0 650		

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0 650	Continued From page 10 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: RN-A had a hire date of November 11, 2022. RN-A's record lacked records of orientation and infection control training. On April 18, 2023, at 11:12 a.m., RN-A indicated she believed she had completed orientation and infection control training but was not sure if there was a record of her completion. RN-A stated she would need to look for the paperwork. The licensee's 4.05 Employee Records Policy dated August 1, 2021, indicated the licensee would retain in the employee record verification of completed orientation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control	0 660		

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0 660	Continued From page 11 and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included completion of a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test for one of one employee (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's TB risk assessment dated March 21, 2023, indicated the licensee was a low risk setting for TB transmission. ULP-B had a hire date of August 16, 2022.	0 660		

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0 660	Continued From page 12 ULP-B provided direct care to residents of the assisted living. ULP-B's employee record lacked a completed TB screening form and documentation of a two-step TST or other evidence of TB screening such as a blood test. During an interview on April 17, 2023, at 1:30 p.m., RN-A stated she was not aware ULP-B did not have evidence of TB screening or TB testing. RN-A stated ULP-B was going to contact her health care provider as she feels she had the TB testing completed when she was at a doctor appointment. The Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, noted baseline screening for all health care workers (HCW) included a history and symptom screen, and testing for the presence of TB infection. The regulations noted a blood test should include the date of the test. The licensee's Tuberculosis Prevention and Control policy dated October 6, 2022, indicated at the time of hire, all staff will be screened for TB. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
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 13 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 observation, interview, and record review, the licensee failed to post an emergency preparedness plan prominently. In addition, the licensee failed to comply with the monthly load test requirements for the facility's emergency power system (permanent generator) as part of the facility's emergency disaster and preparedness plan as required under Minnesota Rules, Part 4659.0100. This had the potential to impact all residents, staff, and visitors to the licensee's facility. 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	0 680		

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0 680	Continued From page 14 or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: POSTING On April 17, 2023, at 10:35 a.m., during a tour of the facility, the surveyor did not observe any signage or information regarding the licensee's emergency disaster or preparedness plan posted in a prominent location. On April 17, 2023, at 11:10 a.m., the surveyor requested the licensee's emergency disaster or preparedness plan. Registered nurse (RN)-A provided a binder consisting of all documents related to the licensee's emergency management plan. During an interview on April 17, 2023, at approximately 2:15 p.m., RN-A stated she was not aware of the need to post the emergency preparedness information for visitors, staff, and residents to view. The licensee's Emergency and Disaster Preparedness policy dated July 29, 2021, indicated the licensee would post the Emergency Disaster Plan prominently. GENERATOR On April 19, 2023, at approximately 12:45 p.m., survey staff requested documentation relating to the emergency system inspections and monthly load test with transfer switch operation records of the emergency power generator as part of the facility's shelter-in-place emergency disaster and preparedness plan for review.	0 680		

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0 680	Continued From page 15 On April 19, 2023, at approximately 1:45 p.m., document review and interview were conducted with licensed assisted living director (LALD)-C and maintenance director (MD)-D indicated the licensee failed to have records that show compliance with the minimum monthly load test requirements for the emergency power generator as outlined under NFPA 110, (as referenced under the Code of Federal Regulations, title 42, section 483.73) to ensure proper performance of the generator. The licensee's records lacked monthly load tests with transfer switch operation as evident with recorded week inspection and quick runs records noting, "quick weekly tests". LALD-C and MD-D verbally confirmed the quick weekly tests were performed without load tests. LALD-C and MD-D verified the above findings during the document review and interview. On April 19, 2023, at approximately 1:45 p.m., LALD-C and DM-D acknowledged the above findings No additional information provided. 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 (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.	0 800		

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0 800	Continued From page 16 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On April 19, 2023, approximately from 10:00 a.m. to 12:30 p.m., survey staff toured the facility with the licensed assisted living director (LALD)-C. During the tour, survey staff observed and the LALD-C verbally and/or visually verified the following: 1. The set of the 1.5-hour fire-rated doors (with magnetic door holders) connecting to the independent living part of the building failed to close and positively latch when released by the LALD-C. 2. The mechanical room with boilers on the 2nd floor had a fan that was not functional. Survey staff observed the room air was very hot and explained to the LALD-C that the fan in the ceiling needed to be repaired. The LALD-C agreed the fan needed to be fixed.	0 800		

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0 800	Continued From page 17 On April 19, 2023, at approximately 1:45 p.m., during the exit interview, the LALD-C and the maintenance director-D acknowledged the above findings. Additional information was received from the LALD-C via email on April 21, 2023, at 1:21 p.m. with attached documentation, annual fire alarm inspection report dated June 24, 2022. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to	0 810		

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0 810	Continued From page 18 include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on document review and interview, the licensee failed to provide the required complete content of the fire safety and evacuation plan, the minimum employee and resident training on fire safety and evacuation, and the minimum evacuation drills. This has the potential to directly affect the safety of all residents receiving services, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On April 19, 2023, at approximately 12:45 p.m. survey staff received the fire safety and evacuation plan and related documentation for review. At approximately, 1:30 p.m., a document review and interview with the licensed assisted living director (LALD)-C and the maintenance director (MD)-D indicated the following:	0 810		

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0 810	Continued From page 19 1. Document review indicated that the fire safety and evacuation plan did not include the identification of unique or unusual resident needs for movement or evacuation under procedures for resident movement, evacuation, or relocation during a fire or similar emergency. Unique resident situations during an evacuation may be residents who have mobility limitations, are non-ambulatory, bedridden, have a cognitive impairment, or any residents needing assistance during an evacuation, and must be addressed in the fire safety and evacuation plan documentation. During the interview, LALD-C verified that the fire safety and evacuation plan for the facility lacked these provisions. 2. Record review indicated the licensee lacked a record of employee training specifically on the required fire safety and evacuation plan twice a year after new employee orientation. Employee training record provided for review, dated February 28, 2023, to March 1, No record on fire safety and evacuation plan was available or provided for review for the previous year 2022. 3. Record review of the available documentation indicated that the licensee did not provide annual training to residents who can assist in their own evacuation on the proper actions to take in the event of a fire including movement, evacuation, or relocation as required by statute. No record was provided or available for review. 4. Record review indicated the licensee failed to perform the required evacuation drills. The record provided for review showed two drills performed to date, May 24, 2022, and September 29, 2021. Survey staff explained to the LALD-C that evacuation drills must be performed twice per year per shift with at least one evacuation drill every other month frequency for a total minimum of six a year.	0 810		

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0 810	Continued From page 20 On April 19, 2023, at approximately 2:00 p.m., at the exit interview, the LALD-C and the MD-D acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (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. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (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 (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.	01060		

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01060	Continued From page 21 (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (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. (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.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to notify the Office of Ombudsman for Long-Term Care (OOLTC) of resident relocation within four days for two of two residents (R6, R7). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's Resident Roster dated April 17, 2023, identified R6's date of admission was September 17, 2022, and date of emergency transfer to a local hospital for evaluation was	01060		

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01060	Continued From page 22 October 14, 2022. R6 did not return to the licensee from the hospital. R6's designated representative was notified at the time of emergency transfer to the hospital. The licensee's Resident Roster dated April 17, 2023, identified R7's date of admission was December 5, 2022, and date of emergency transfer to a local hospital for evaluation was January 22, 2023. R7 did not return to the licensee from the hospital. R7's designated representative was notified at the time of emergency transfer to the hospital. R6 and R7's records lacked documentation the OOLTC was notified of the resident relocations. During interview on April 18, 2023, at approximately 10:15 a.m., licensed assisted living director (LALD)-C and registered nurse (RN)-A stated they were not aware that the Regional Ombudsman needed to be notified when a resident was out of the establishment for more than four days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01330 SS=D	144G.60 Subd. 4 (b) Unlicensed personnel (b) Unlicensed personnel performing delegated nursing tasks in an assisted living facility must: (1) have successfully completed training and demonstrated competency by successfully completing a written or oral test of the topics in	01330		

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01330	Continued From page 23 section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform; (2) satisfy the current requirements of Medicare for training or competency of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or 484.36; or (3) have, before April 19, 1993, completed a training course for nursing assistants that was approved by the commissioner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to complete training and competency evaluations in all required training topics for one of one employee (unlicensed personnel (ULP)-B). 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: ULP-B had a hire date of August 16, 2022. ULP-B's record lacked documentation of successful completion of training and demonstrated competency by successfully completing a written or oral test of the topics in	01330		

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01330	Continued From page 24 section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform. During interview on April 18, 2023, at 11:45 a.m., registered nurse (RN)-A stated the licensee provided ULPs with orientation and all required trainings by way of an online education program as well as a training manual provided by the licensee. RN-A stated once the ULPs completed the training, RN-A would observe ULPs demonstrated competency to ensure they could perform the skills required of their position. RN-A stated she was not employed at the time of ULP-B's orientation and was not aware this was not completed with ULP-B. On April 17, 2023, at 12:00 p.m., licensed assisted living director (LALD)-C verified ULP-B's record lacked evidence of completed training and competency testing in all required training topics. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01330		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility;	01370		

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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
01370	Continued From page 25 (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency was completed for one of one unlicensed personnel (ULP)-B).	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33651	A. BUILDING: _____ B. WING _____	04/19/2023

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01370	Continued From page 26 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: ULP- B was hired on August 16, 2022. ULP-B's training record lacked evidence of the following education and/or competencies had been completed prior to providing direct cares: - documentation requirements for all services provided; - maintenance of a clean and safe environment; - medication, exercise, and treatment reminders; - communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; - awareness of confidentiality and privacy; - understanding appropriate boundaries between staff and residents and the resident's family; - procedures to utilize in handling various emergency situations; and - awareness of commonly used health technology equipment and assistive devices. During interview on April 18, 2023, at 11:45 a.m., registered nurse (RN)-A stated the licensee provided ULPs with orientation and all required trainings by way of an online education program as well as a training manual provided by the licensee. RN-A stated once the ULPs completed the training, RN-A would observe ULPs demonstrated competency to ensure they could	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01370	Continued From page 27 perform the skills required of their position. RN-A stated she was not employed at the time of ULP-B's orientation and was not aware this was not completed with ULP-B. During interview on April 18, 2023, at 1:15 p.m., ULP-B stated she did not receive any training from an RN at the time of hire. ULP-B stated she worked with other unlicensed staff members to learn the licensee's systems. ULP-B also stated she did not complete any competency evaluations with an RN. The licensee's Required Training for All Employees, Minnesota Assisted Living policy dated August 1, 2021, indicated instruction training and competency evaluations of ULPs providing assisted living services will be conducted by an RN. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident;	01380		

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	33651	A. BUILDING: _____ B. WING _____	04/19/2023

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01380	Continued From page 28 (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure competency evaluations were completed by a registered nurse (RN), for one of one unlicensed personnel ((ULP)-B). 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: ULP-B was hired on August 16, 2022. ULP-B's employee records lacked competency evaluation for the following: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; and	01380		

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01380	Continued From page 29 (6) range of motioning and positioning. During interview on April 17, 2023, at 11:30 a.m., ULP-B stated they were trained with other staff members by viewing online education training sessions and reviewing the training with the staff that were at the training session. During interview on April 18, 2023, at 11:45 a.m., registered nurse (RN)-A stated the licensee provided ULPs with orientation and all required trainings by way of an online education program as well as a training manual provided by the licensee. RN-A stated once the ULPs completed the training, RN-A would observe ULPs demonstrated competency to ensure they could perform the skills required of their position. RN-A stated she was not employed at the time of ULP-B's orientation and was not aware this was not completed with ULP-B. During interview on April 18, 2023, at 1:15 p.m., ULP-B stated she did not receive any training from an RN at the time of hire. ULP-B stated she worked with other unlicensed staff members to learn the licensee's systems. ULP-B also stated she did not complete any competency evaluations with an RN. The licensee's 5.08 Instructor and Competency Evaluation Requirements policy dated August 1, 2021, indicated training and competency evaluations of unlicensed personnel providing assisted living must be conducted by a registered nurse. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		

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	33651	A. BUILDING: _____ B. WING _____	04/19/2023

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01460 SS=D	144G.63 Subdivision 1 Orientation of staff and supervisors 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 orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff providing services completed an orientation to assisted living facility licensing requirements and regulations before providing services for one of one employee (registered nurse (RN)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: RN-A began providing direct care services to residents on November 11, 2022. RN-A's employee record lacked the required orientation to assisted living licensing requirements and regulations with the required content.	01460		

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01460	Continued From page 31 On April 17, 2023, at 2:30 p.m., RN-A verified the lack of employee orientation records for herself. RN-A stated she had not completed an orientation to the assisted living licensing requirements and regulations. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01460		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on the document review and interview, the licensee failed to develop a memory care site-specific safety risk assessment plan to identify hazard vulnerabilities and mitigations on and around the property to protect memory care residents from harm. This has the potential to directly affect staff, visitors, and all memory care residents receiving assisted living services. This practice resulted in a level two violation (a	02040		

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02040	Continued From page 32 violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients). The findings include: On April 19, 2023, at approximately 1:15 p.m., a document review and interview with the licensed assisted living director (LALD)-C and the maintenance director (MD)-D indicated the licensee failed to develop the memory care site-specific safety risk assessment and mitigation plan to identify vulnerabilities and mitigations on and around the property to protect the memory care residents from harm. This finding was evident as there was no site-specific plan documentation provided for review and was confirmed during the interview with the LALD-C that the licensee lacked these provisions. On April 19, 2023, at approximately 1:30 p.m., during the exit interview survey staff discussed the findings and explained to the LALD-C and the MD-D that all potential safety risks and/or vulnerabilities on and around the property including the opened serving kitchen, hot food well between serving kitchen and dining, and toasters must be identified, assessed, and mitigated and be documented in the plan to protect the memory care residents from harm. The LALD-C acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	02040		

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02040	Continued From page 33 (21)	02040		
02140 SS=F	144G.83 Subd. 3 Supervising staff training Persons providing or overseeing staff training must have experience and knowledge in the care of individuals with dementia, including: (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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to designate a qualified person to oversee staff training in the care of individuals with dementia. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Registered nurse (RN)-A had a hire date of November 11, 2022, and provided supervision and training to unlicensed personnel (ULP) in the licensee's assisted living with dementia care establishment. RN-A's employee record lacked	02140		

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02140	Continued From page 34 documentation of completion of an approved competency and knowledge test as required for supervising staff in an assisted living facility with dementia care. During the entrance conference on April 17, 2023, at approximately 10:30 a.m., RN-A stated she oversaw training staff in the care of individuals with dementia. On April 18, 2023, at approximately 12:00 p.m., RN-A stated she had not completed an approved competency and knowledge test required for supervising staff in an assisted living facility with dementia care. RN-A also stated there were no other staff members hired by licensee that had completed an approved competency and knowledge test required for supervising staff in an assisted living facility with dementia care. No further information was provided. TIME PERIOD TO CORRECT: Twenty-One (21) days	02140		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee	03090		

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03090	Continued From page 35 failed to ensure a required notice was posted at the main entry way of the licensee's facility to display statutory language to disclose electronic monitoring activity. 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). The findings include: On April 17, 2023, at 10:00 a.m., during a tour of the facility, the surveyor observed no electronic monitoring notice posted at the entrance to the licensee's facility. On April 18, 2023, 11:32 a.m., licensed assisted living director (LALD)-C acknowledged the licensee failed to post the required electronic monitoring notice. LALD-C stated she believe the signage was posted at one time but was not aware it had been removed. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090		

Minnesota Department of Health
Food, Pools, Lodging
18 Woodlake Dr. SE
Rochester
507-206-2700

Type: Full
Date: *04/17/23*
Time: 12:55:09
Report: 8074231084

Food and Beverage Establishment Inspection Report

Location:
Springbrook Village Lacrescent
1384 County Road 25
La Crescent, MN55947
Houston County, 28

Establishment Info:
ID #: 0039217
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5075512034
ID #:

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

The following orders were issued during this inspection.

2-200 Employee Health

2-201.11C ** Priority 1 **

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

Comply By: 04/18/23

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.

Butter on counter in serving kitchens 67 and 71 df. Butter must remain 41df or below.

Comply By: 04/17/23

2-500 Responding to contamination events

2-501.11 ** Priority 2 **

MN Rule 4626.0123 Provide employees with procedures to follow for cleanup of vomit or fecal matter in the establishment. The procedures must minimize the spread of contamination to food and surfaces within the facility, and minimize the exposure of employees and consumers to contamination.

Comply By: 04/17/23

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.

Comply By: 04/17/23

4-200 Equipment Design and Construction

4-204.112A

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

upright cooler missing thermometer.

Comply By: 04/18/23

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

Sign needed in memory care and upstairs serving kitchen.

Comply By: 04/18/23

Surface and Equipment Sanitizers

Chlorine: = 50ppm at Degrees Fahrenheit
Location: dish machine
Violation Issued: No

Quaternary Ammonia: = 400ppm at Degrees Fahrenheit
Location: sanitizer bucket
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cooling
Temperature: 44 Degrees Fahrenheit - Location: ham just diced (walk-in)
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: soup
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 38 Degrees Fahrenheit - Location: noodles, grapes
Violation Issued: No

Type: Full
Date: *04/17/23*
Time: 12:55:09
Report: 8074231084
Springbrook Village Lacrescent

Food and Beverage Establishment Inspection Report

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

Process/Item: On Counter
Temperature: 67 Degrees Fahrenheit - Location: butter
Violation Issued: Yes

Process/Item: On Counter
Temperature: 71 Degrees Fahrenheit - Location: butter
Violation Issued: Yes

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: milk
Violation Issued: No

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

In between managers, location of illness log unknown.

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 8074231084 of 04/17/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Signed:_____
Establishment Representative

Signed: Andrea Kieffer

Andrea Kieffer

507-206-2721
andrea.kieffer@state.mn.us