Electronically Delivered

March 14, 2024

Licensee
Chosen Valley Assisted Living
1260 Winona Street Southeast
Chatfield, MN 55923

RE: Project Number(s) SL30494015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 22, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

The correction order documentation should include the following:

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Renee L Anderson

Renee Anderson, Supervisor
State Evaluation Team
Email: renee.anderson@state.mn.us
Telephone: 651-201-5871 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
	30494	A. BUILDING: _____ B. WING _____	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOSEN VALLEY ASSISTED LIVING	1260 WINONA STREET SE CHATFIELD, MN 55923

(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: SL30494015-0 On February 20, 2024, through February 22, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 15 residents; 15 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. 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 pursuant to 144G.31 Subd. 1, 2 and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according	0 480		

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0 480	Continued From page 1 to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated February 22, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 485 SS=C	144G.41 Subdivision 1. (13)(i)(A)and(C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United	0 485		

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0 485	Continued From page 2 States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure meal substitutions were of similar nutritional value when a resident refused a food that was served. This had the potential to affect all residents of the licensee. 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 the residents). The findings include: On February 21, 2024, at 10:00 a.m., R2 stated meal substitutions were not offered and residents "don't get anything else" if they did not like what was being served. -at 11:00 a.m., the surveyor observed the menu plan posted on a wall in the common area. The	0 485		

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0 485	Continued From page 3 menu was titled, "February 18-February 24", and the alternatives listed on the menu were blackened out with a marker. - at 1:10 p.m., dietary manager (DM)-F stated alternatives were not offered unless a resident had an allergy. DM-F further stated, "the board said we didn't have to offer an alternative anymore." The licensee's 12.01 Food Service and Menu Planning policy dated August 1, 2021, indicated meal substitutions would be of similar nutritional value if a resident refused a food that was served. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health.	0 550		

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0 550	Continued From page 4 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to post the required information related to the grievance procedure. This had the potential to affect all the 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) 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: On February 20, 2024, at 12:00 p.m., the surveyors observed the common areas of the facility and noted the licensee lacked a posting of the grievance procedure, including the name, telephone number, and e-mail contact information for the individuals who were responsible for handling resident grievances. On February 21, 2024, at 1:20 p.m., licensed assisted living director (LALD)-A stated the required information was included in the licensee handbook and provided to residents upon admission. LALD-A verified the information was not posted in a conspicuous place, as required. The licensee's Complaint/Grievance policy, dated August 1, 2021, indicated a "a complaint form should be filled out by the resident, resident representative, or employee and given to the supervisor of the department or to the Assisted	0 550		

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0 550	Continued From page 5 Living Director." The policy did not address posting of the required information related to the grievance procedure. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers as required by statute. This deficient condition 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	0 790		

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0 790	Continued From page 6 or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On February 21, 2024, at 10:00 a.m., survey staff toured the facility with maintenance director (MD)-E. During the tour, survey staff observed the tags attached to the portable fire extinguishers did not have the required number of monthly inspections recorded. No monthly inspections were recorded for January 2024. Several of the tags did not have monthly inspections recorded for December 2023. Fire extinguisher inspections must be conducted every month to ensure each extinguisher is in its designated place, it has not been tampered with, and there is no obvious physical damage or condition that would interfere with its use or operation. During the facility tour interview, MD-E verified fire extinguisher inspections had not been completed every month. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.	0 800		

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0 800	Continued From page 7 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents, 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 February 21, 2024, at 10:00 a.m., survey staff toured the facility with maintenance director (MD)-E. During the tour, survey staff observed the following: 1. The fire door and door closer were removed between rooms 120 and 121. 2. Door closers were missing from the fire doors for storage room 131, medical records room 219, and janitor room 226. 3. The door closer was disconnected from the fire door in office room 126. Fire doors must be installed and maintained as designed to protect the opening in which they were installed and to protect adjacent spaces. 4. The fire door was held open by a wedge in laundry room 225. Wedging fire doors in the open position prohibits the required operation and closing feature of the door. 5. A curtain was installed on the exit door leading out to the patio from gathering room 123. Means	0 800		

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0 800	Continued From page 8 of egress doors shall be easily recognizable as doors and not concealed by curtains. 6. Electrical panels were obstructed by boxes in medical records room 219 and janitor room 226. Sufficient clearance above, below, and around electrical panels shall be provided. During the facility tour interview, MD-E verified the missing fire door, missing and disconnected door closers, door wedge, and electrical panel obstruction. TIME PERIOD FOR CORRECTION: Seven (7) 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	0 810		

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0 810	Continued From page 9 their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, record review and interview, the licensee failed to develop a fire safety and evacuation plan with the required content, and provide required training and drills. This had the potential to directly 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 potential to affect a large portion or all the residents). The findings include: On February 21, 2024, at 10:00 a.m., survey staff toured the facility with maintenance director (MD)-E. During the tour, survey staff observed the posted evacuation floor plans did not identify the location and number of resident sleeping rooms. During the facility tour interview, MD-E verified the resident rooms were not identified. On February 21, 2024, at 10:00 a.m., survey staff toured the facility with MD-E. During the tour, survey staff did not observe the fire safety and	0 810		

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0 810	Continued From page 10 evacuation plan (FSEP) in a central location for all staff accessibility. During an interview on February 21, 2024, at 12:00 p.m., MD-E stated the FSEP was located in the care center. On February 21, 2024, MD-E provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and employee evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN During an interview on February 21, 2024, at 12:00 p.m., MD-E stated a FSEP had not been developed for the assisted living building. TRAINING Record review indicated the licensee lacked documentation they provided training to employees on the FSEP upon hire and/or at least twice per year. During an interview with survey staff on February 21, 2024, at 12:00 p.m., MD-E explained employees completed fire safety and evacuation training using healthcare academy. MD-E stated no training records were available to document training regarding the facility FSEP. Record review indicated the licensee lacked documentation of fire safety and evacuation training provided to residents at least once per year. During an interview with survey staff on February 21, 2024, at 12:00 p.m., MD-E explained residents were trained upon admission and no annual training records were available. DRILLS 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 a review of the completed fire drill logs. In 2021, one fire drill was recorded in October at 2:20 p.m.. In 2022, fire drills were recorded in April and June, both during the day shift. An actual fire event was recorded as a fire drill in October during the day shift. During an interview with survey staff on February	0 810		

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0 810	Continued From page 11 21, 2024, at 12:00 p.m., MD-E verified the licensee had not met the evacuation drill frequency. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure service plans had been signed or authenticated by the resident, or the resident's representative for two of two residents (R1 and R2).	01640		

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01640	Continued From page 12 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: R1 and R2's records lacked a service plan that had been signed or authenticated by the resident or the resident's representative. R1 R1's service plan dated January 19, 2024, indicated R1 had diagnoses including diabetes, and received services to include assistance with medication administration. R2 R2's service plan dated January 23, 2024, indicated R2 had diagnoses including diabetes, and received services to include assistance with medication administration. On February 21, 2024, at 8:00 a.m., and 8:45 a.m., unlicensed personnel (ULP)-D was observed to administer prescribed medications to R1 and R2 respectively. On February 21, 2024, at 1:20 p.m., licensed assisted living director (LALD)-A verified the service plans for the residents included all cares and services provided, but did not include a signature by the resident or resident's representative.	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30494	A. BUILDING: _____ B. WING _____	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOSEN VALLEY ASSISTED LIVING	1260 WINONA STREET SE CHATFIELD, MN 55923

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01640	Continued From page 13 The licensee's Service Plan policy, dated August 1, 2021, indicated "the service plan and any revisions hall include a signature or other authentication by the [licensee] and by the resident, or resident's representative, documenting agreement on the services to be provided." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30494	A. BUILDING: _____ B. WING _____	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOSEN VALLEY ASSISTED LIVING	1260 WINONA STREET SE CHATFIELD, MN 55923

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01650	Continued From page 14 (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure resident service plans included all the required content for two of two resident (R1 and R2). 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: R1 R1's service plan dated January 19, 2024, indicated R1 had diagnoses including diabetes, and received services to include assistance with medication administration. R2 R2's service plan dated January 23, 2024, indicated R2 had diagnoses including diabetes, and received services to include assistance with medication administration. R1 and R2's service plans lacked the following required content: -the schedule and methods of monitoring assessments of the resident; and	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30494	A. BUILDING: _____ B. WING _____	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOSEN VALLEY ASSISTED LIVING	1260 WINONA STREET SE CHATFIELD, MN 55923

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01650	Continued From page 15 -the schedule and methods of monitoring staff providing services. On February 21, 2024, at 8:00 a.m. and 8:45 a.m., unlicensed personnel (ULP)-D was observed to administer prescribed medications to R1 and R2 respectfully. On February 21, 2024, at 1:20 p.m., licensed assisted living director (LALD)-A verified the service plans for the licensee residents included all cares and services provided, but lacked the above required information. The licensee's Service Plan policy, dated August 1, 2021, indicated the service plan would include, "a schedule and method for the next planned assessment or monitoring and a schedule and method for the next planned monitoring of staff providing services." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		

MDH
EH-FPLS
18 Wood Lake Dr
Rochester
507-206-2700

Type: Full
Date: *02/22/24*
Time: 14:34:15
Report: 1045241035

Food and Beverage Establishment Inspection Report

Location:
Chosen Valley Assisted Living
1260 Winona Street Se
Chatfield, MN55923
Fillmore County, 23

Establishment Info:
ID #: 0038927
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5078673416
ID #:

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

The following orders were issued during this inspection.

4-900 Protecting Clean Items

4-904.11A

MN Rule 4626.0965A Handle, display, and dispense all single-service and single use articles and clean utensils so that contamination of lip-contact and food-contact surfaces is prevented.

Utensils stored unprotected at the breakfast display. Discussed dispensing options

Comply By: 02/22/24

Surface and Equipment Sanitizers

Chlorine: = 50 PPM at Degrees Fahrenheit
Location: Mechanical WW (Nursing Home)
Violation Issued: No

Quaternary Ammonia: = 200 PPM at Degrees Fahrenheit
Location: Quat Spray Bottle
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 41F Degrees Fahrenheit - Location: True Upright Ref - Sour Cream
Violation Issued: No

Process/Item: Cold Holding
Temperature: 41F Degrees Fahrenheit - Location: Frigidaire - Pudding
Violation Issued: No

Type: Full
Date: *02/22/24*
Time: 14:34:15
Report: 1045241035
Chosen Valley Assisted Living

Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding
Temperature: 35F Degrees Fahrenheit - Location: WI Cooler (Nursing Home) - ambient
Violation Issued: No

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

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the MDH inspection report number 1045241035 of 02/22/24.

Certified Food Protection Manager: Trischa Doucette

Certification Number: FM117289 Expires: 05/03/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
Trischa Doucette
Dietary Director

Signed: _____
Nicole Hunger
Public Health Sanitarian
Rochester District Office
nicole.hunger@state.mn.us

Report #: 1045241035

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

MDH
EH-FPLS
18 Wood Lake Dr
Rochester

No. of RF/PHI Categories Out	0
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 02/22/24
Time In 14:34:15
Time Out

Chosen Valley Assisted Living	Address: 1260 Winona Street Se	City/State: Chatfield, MN	Zip Code: 55923	Telephone: 5078673416

License/Permit #: 0038927	Permit Holder	Purpose of Inspection: Full	Est Type	Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

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

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

Food Recalls:

Person in Charge (Signature) **Date:** 02/22/24

Inspector (Signature)