DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

October 20, 2022

Administrator
Hillcrest Senior Living
311 Broadway Avenue Northeast
Red Lake Falls, MN 56750

RE: Project Number(s) SL31767015

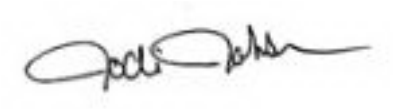
Dear Administrator:

On October 13, 2022, the Minnesota Department of Health completed a follow-up evaluation of your agency to determine if orders from the September 14, 2022, evaluation were corrected. This follow-up evaluation verified that the agency is in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your agency's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,



Jodi Johnson, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 651-215-9697

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Electronically Delivered

September 20, 2022

Administrator
Hillcrest Senior Living
311 Broadway Avenue Northeast
Red Lake Falls, MN 56750

RE: Project Number(s) SL31767015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on September 14, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

St - 0 - 2310 - 144g.91 Subd. 4 - Appropriate Care And Services - $3,000.00

The total amount you are assessed is $3,000.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

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

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

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

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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

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 Department of Health within 15 business days of the correction order receipt date. 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 this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Jessica Chenze, Interim Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jessica.chenze@state.mn.us
Telephone: 218-332-5175 | Fax: 218-332-5196

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31767	A. BUILDING: _____ B. WING _____	09/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST SENIOR LIVING	311 BROADWAY AVENUE NE RED LAKE FALLS, MN 56750

(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 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: SL#31767015 On, September 12, 2022, through September 14, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 26 residents, all of whom received services under the provider's Assisted Living Dementia Care license. An immediate correction order was identified on September 13, 2022, issued for SL#31767015, tag identification 2310. On September 13, 2022, the immediacy of correction order 2310 was removed, however non-compliance remained at a scope and level of I.	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 Home Care/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 144A.474 subd. 11 (b) (1) (2) -or- 144G.31 subd. 1, 2 and 3.	

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0 470	Continued From page 1	0 470		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (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 interview and record review, the licensee failed to develop and implement a staffing plan to determine staffing levels to meet the needs of the residents. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a	0 470		

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0 470	Continued From page 2 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 held an assisted living with dementia care license. The facility was licensed for a capacity of 26 residents and had a current census of 26 residents. During the entrance conference on September 12, 2022, at 9:57 a.m., the surveyor asked for a copy of the facility's staffing plan. Licensed assisted living director (LALD)-A stated the facility was "working on this" however did not have a formalized written staffing plan developed. LALD-A stated the usual staffing schedule for the facility was as follows: - RN on site 40 hours a week - the day shift was staffed with two unlicensed personnel (ULP) from 6:00 a.m. to 2:00 p.m.; two ULP from 7:00 a.m. to 3:00 p.m.; and one ULP from 7:00 a.m. to 11:00 a.m. - the evening shift was staffed with two ULP from 2:00 p.m. to 10:00 p.m.; two ULP from 3:00 p.m. to 9:00 p.m., and one ULP from 4:30 p.m. to 7:00 p.m. - the night shift was staffed with two ULP from 10:00 p.m. to 6:00 a.m. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 470		

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0 480	Continued From page 3	0 480		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated September 12, 2022, for the specific	0 480		

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0 480	Continued From page 4 Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
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 quality management activity appropriate to the size and relevant to the type of services provided by the assisted living. This had the potential to affect all 26 residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 580		

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0 580	Continued From page 5 The findings include: During the entrance conference on September 12, 2022, at 10:45 a.m., the surveyor asked licensed assisted living director (LALD)-A for the documentation of the licensee's quality management activities. The Quality Assurance (QA) book provided had the meeting minutes from their last meeting which was held on January 10, 2020. On September 12, 2022, at 2:14 p.m., LALD-A stated the facility did not have a current ongoing quality management activity. LALD-A stated she thought the facility would focus on the usage of psychotropic medications. The licensee's Quality Improvement Project policy dated October 14, 2014, noted the facility would have at least one documented quality improvement project in place at all times, and retain records of such projects for at least two years. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580		
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 and Prevention (CDC), Division of Tuberculosis	0 660		

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0 660	Continued From page 6 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 ensure the provider established and maintained 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 an annual facility risk assessment and ensuring the completion of baseline TB screenings such as a blood test was completed for one of three employees (unlicensed personnel/ULP-G). 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: TB RISK ASSESSMENT During the entrance conference on September 12, 2022, at 10:42 a.m., the surveyor asked for the licensee's facility TB risk assessment, which was provided to and later reviewed by the	0 660		

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0 660	Continued From page 7 surveyor. The licensee's facility TB risk assessment was dated July 16, 2021. The facility had been identified as low risk. On September 12, 2022, at 2:20 p.m., licensed assisted living director (LALD)-A stated a facility TB risk assessment should have been completed by July 16, 2022, and we didn't do one, so we are late. LALD-A stated the TB facility risk assessments should be completed annually. TB SCREENING ULP-G had a hire date of June 13, 2022. ULP-G's employee record included a completed Baseline TB Screening Tool for Health Care Workers (HCWs) dated June 13, 2022. ULP-G's employee record also included the results of a negative QuantiFERON (IGRA-a blood test that aids in the detection of Mycobacterium tuberculosis, the bacteria that causes TB) which had been completed on April 2, 2018 (over four years from hire date). On September 14, 2022, at 12:12 p.m., registered nurse (RN)-B and LALD-A confirmed ULP-G's QuantiFERON test was completed greater than 90 days from her hire date. RN-B stated she thought the QuantiFERON test was one that only needed to be completed once in a lifetime. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative	0 660		

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0 660	Continued From page 8 IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The MDH Tuberculosis (TB) Screening and Education Requirements for Assisted Living Facilities and Home Care Providers dated February 3, 2022, indicated TB risk assessments should be completed annually. In addition, negative IGRA tests can be accepted if dated within 90 days before hire. The licensee's TB Plan, Staff Screening, Resident Assessment policy dated July 1, 2015, noted a facility TB risk assessment would be completed annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 660		
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. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect	0 800		

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0 800	Continued From page 9 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 residents). The findings include: On September 13, 2022, from approximately 1:20 p.m. to 2:55 p.m., survey staff toured the facility with Licensed Assisted Living Director (LALD)-A and Maintenance Director (MD)-H. During the facility tour, survey staff observed and verified padlocks installed on the memory courtyard gate. The gate was locked which removed a safe means of egress during a fire or similar emergency. This was evident as the memory care unit had one identified exit doors inside the building directing people to exit into the locked courtyard. This proposed exit path was also shown on the facility's evacuation plan. Also, during the facility tour, survey staff observed and verified the following maintenance issues: 1. Hole in the ceiling above the sprinkling system in the boiler room. 2. Bottom of the outside door in the boiler room had some gaps exposing the element to the outdoors. On September 13, 2022, at approximately 2:20 p.m., LALD-A and MD-H verbally confirmed survey staff observations. No further information provided.	0 800		

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0 800	Continued From page 10 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual begins working for the licensee for one of one unlicensed personnel (ULP)-G.	01440		

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HILLCREST SENIOR LIVING	311 BROADWAY AVENUE NE RED LAKE FALLS, MN 56750

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01440	Continued From page 11 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: On September 13, 2022, at 7:41 a.m., the surveyor observed ULP-G apply R2's compression stockings (specialized hosiery that are used to improve the blood flow in the veins of the legs) and transfer R2 from the bed to the wheelchair using a Hoyer lift (mechanical lifting device). ULP-G was hired on June 13, 2022, to provide direct care services to residents at the assisted living with dementia care facility. ULP-G's employee record lacked documentation of a registered nurse (RN) supervising ULP-G performing a delegated task within 30 days of beginning work with the licensee. On September 14, 2022, at 12:14 p.m., RN-B stated ULP-G's 30-day supervision of performing a delegated task had not been completed as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		

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01470	Continued From page 12	01470		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any	01470		

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01470	Continued From page 13 training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure orientation to assisted living statutes included all the required content for one of three employees (registered nurse/RN-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: RN-B was hired on October 25, 2017, in the role as an unlicensed personnel (ULP) to provide	01470		

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01470	Continued From page 14 direct care services to the residents. On June 15, 2022, RN-B was hired as the clinical nurse supervisor for the facility to provide direct care to the residents and supervise the staff. RN-B's employee record lacked the following required orientation content: - an overview of the 144G statutes - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights - a review of the types of assisted living services the employee will be providing and the facility's category of licensure, and - the principles of person-centered planning and services delivery and how they apply to direct support services provided by the staff person. On September 14, 2022, at 12:10 p.m., RN-B and licensed assisted living director (LALD)-A reviewed RN-B's employee records and stated RN-B had not completed the above noted orientation as required. The licensee's undated Employee General Orientation policy noted upon hire and prior to performing any functions of their position at [facility name], each new employee and volunteer will be orientated in accordance with State and Federal regulations, as well as company policy and procedure. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		
01880 SS=F	144G.71 Subd. 19 Storage of medications	01880		

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01880	Continued From page 15 An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure stock medications were stored according to the manufacturer's recommended temperature. 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 September 12, 2022, at 11:08 a.m., the surveyor reviewed the medication refrigerator located in the locked medication room with licensed practical nurse (LPN)-C. The temperature of the refrigerator was observed to be 36 degrees Fahrenheit (F). There was a total of 66 bisacodyl 10 milligram (mg) suppositories stored in the medication refrigerator. LPN-C stated these suppositories were stock medications. On September 12, 2022, at 11:10 a.m., the surveyor and LPN-C reviewed the manufacturer guidelines located on the outside of the bisacodyl box of suppositories. LPN-C stated according to the directions the suppositories should be stored	01880		

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01880	Continued From page 16 at temperatures between 68-77 degrees F and not in the refrigerator. The licensee's undated Medication Storage policy, noted medications would be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure medications were maintained with legible information including the expiration date for time sensitive medications for three of five residents (R1, R5, R6). 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be	01890		

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01890	Continued From page 17 pervasive). The findings include: On September 12, 2022, at 11:12 a.m., the surveyor toured the facility with the licensed assisted living director (LALD)-A, including a review of the locked medication cart with licensed practical nurse (LPN)-C. LPN-C observed and confirmed the following: R1 R1's opened Novolog 100 units/milliliter (ml) insulin pen lacked a label to indicate when the insulin pen was opened and when the insulin pen would expire. R1's opened Symbicort 80 microgram (mcg)/4.5 mcg inhaler (bronchodilator) lacked a label to indicate the date the inhaler was removed from the foil pouch and when the inhaler would expire. R5 R5's opened Advair Diskus 100 mcg/50 mcg inhaler (bronchodilator) lacked a label to indicate the date the inhaler was removed from the foil pouch and when the inhaler would expire. R6 R6's opened Basaglar 100 units/ml insulin pen lacked a label to indicate when the insulin pen was opened and when the insulin pen would expire. On September 12, 2022, at 11:21 a.m., LPN-C stated the staff know they are supposed to date all insulin pens when they are first opened and the above noted medications must have been missed. LPN-C stated inhalers were not routinely dated when they were opened.	01890		

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01890	Continued From page 18 The manufacturer's instructions for Novolog, dated June 2021, directed to discard the pen 28 days after it had been opened, even if there is insulin left in the pen. The manufacturer's instructions for the Symbicort inhaler, dated January 2021, directed to discard the inhaler when the counter reaches zero or three months after it was removed out of its foil pouch, whichever comes first. The manufacturer's instructions for Advair Diskus inhaler dated August 2020, directed to discard the inhaler one month after opening the foil pouch. The manufacturer's instructions for Basaglar insulin pens dated September 2021, directed to discard the pen 28 days after it had been opened, even if it still had insulin left in it. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service	01910		

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01910	Continued From page 19 contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medications as required for one of one resident (R4) upon discharge. 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: R4 was admitted for services on April 2, 2020, and discharged on July 12, 2022. R4's diagnoses included dementia, hypertension (high blood pressure), diabetes, schizophrenia (a mental health condition in which people interpret reality abnormally which may result in a combination of hallucinations, delusions, and extremely disordered thinking and behavior that	01910		

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01910	Continued From page 20 impairs daily functioning) and drug induced Parkinson's (a chronic progressive neurological disease which exhibits symptoms such as tremors, rigidity, impaired balance, slowness of movement and shuffling of gait). R4's Service Plan dated August 1, 2021, noted R4 received mediation management services which included mediation administration. R4's July 2022, Mediation Administration Summary indicated R4 received the following scheduled medications: - carbidopa/levodopa (mediation to treat Parkinson's) 25-100 milligram (mg) two tablets daily; - Constulose (laxative) 10 grams (g)/15 milliliters (ml) three times daily; - Divalproex Sodium (anticonvulsant) 500 mg three times daily; - gabapentin (anticonvulsant) 600 mg three times daily; - gavilax powder (laxative) 17 g twice daily; - glipizide (anti-diabetic) 10 mg daily; - Invokana (anti-diabetic)100 mg daily; - levothyroxine (thyroid hormone replacement) 50 micrograms (mcg) daily; - lorazepam (sedative) 0.5 mg three times daily; - magnesium oxide (mineral replacement) 400 mg daily; - metformin (anti-diabetic) 1000 mg daily; - olanzapine (antipsychotic) 5 mg twice daily; - vitamin D3 25 mcg daily; - glipizide (anti-diabetic) 10 mg daily; - atorvastatin (cholesterol lowering medication) 40 mg at bedtime; - Basaglar Kwikpen (insulin) 100 units/ml inject 20 units subcutaneously (sq) nightly; and - Victoza (anti-diabetic)18 mg/3 ml pen inject 1.8 mg sq daily.	01910		

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01910	Continued From page 21 R4's Discharge - Transfer Summary dated July 11, 2022, noted all medications would be sent with the resident including insulin. R4's record lacked a disposition of medications to include: - the mediation name; - strength; - prescription number as applicable; - quantity; - to whom the medications were given; - date of disposition; and - names of staff and other individuals involved in the disposition. On September 12, 2022, at 3:57 p.m., licensed assisted living director (LALD)-A stated R4's record lacked the required content for the disposition of medications noted above. LALD-A stated she would educate the registered nurse (RN) of what information needs to be documented when a resident transfers to another facility with regards to disposition of medications. The licensee's undated Medication Disposition policy outlined the step-by-step procedure for documenting medication disposition for when a resident was discharged and/or transferred. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and	02110		

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02110	Continued From page 22 procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement all required policies and procedures related to dementia care. In addition, the licensee failed to ensure the required dementia care policies and	02110		

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02110	Continued From page 23 procedures were provided to each resident and/or the resident's legal and designated representatives. 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: The facility currently held an Assisted Living with Dementia Care license. On September 12, 2022, at 10:11 a.m., during the entrance conference, the surveyor asked for the licensee's assisted living with dementia care policies and procedures. The Special Care Disclosure policy provided did not include the following: - evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; - medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; - limiting the use of public address and intercom systems for emergencies and evacuation drills only; - transportation coordination and assistance to and from outside medical appointments; and - safekeeping of residents' possessions.	02110		

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02110	Continued From page 24 On September 14, 2022, at 10:45 a.m., licensed assisted living director (LALD)-A stated the above noted dementia care policies and procedures had not been developed as required. LALD-A stated the only dementia care policy that is provided to the resident and/or their representative is the Special Care Disclosure policy. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02110		
02170 SS=D	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks;	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31767	A. BUILDING: _____ B. WING _____	09/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST SENIOR LIVING	311 BROADWAY AVENUE NE RED LAKE FALLS, MN 56750

(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
02170	Continued From page 25 (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have an evaluation for activities and an individualized activity plan developed for one of two residents (R1) who received services under an assisted living with dementia care license. 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: The facility currently held an Assisted Living with Dementia Care license. R1's diagnoses included dementia, diabetes, and sleep apnea (a potentially serious sleep disorder in which breathing repeatedly stops and starts).	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31767	A. BUILDING: _____ B. WING _____	09/14/2022

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02170	Continued From page 26 R1's record lacked an evaluation for activities to include: - past and current interests - current abilities and skills - emotional and social needs and patterns; and - adaptations necessary for the resident to participate In addition, R1's record lacked the development of an individualized activity plan. On September 14, 2022, at 11:00 a.m., licensed assisted living director (LALD)-A stated an activity evaluation and plan had not been completed for R1 as required. The licensee's undated ALDC Life Enrichment Programs, Activities and Outdoor Space policy noted each resident must be evaluated for activities according to the licensing rules of the facility. An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02170		
02310 SS=I	144G.91 Subd. 4 Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards.	02310		

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	31767	A. BUILDING: _____ B. WING _____	09/14/2022

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02310	Continued From page 27 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for three of three residents (R1, R2, R3) with bedrails. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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). This resulted in an immediate correction order on September 13, 2022, at 12:36 p.m. The findings include: R1 On September 13, 2022, at 7:08 a.m., the surveyor observed R1 laying in a hospital bed with bilateral upper bedrails in the upright position. At 9:00 a.m., the surveyor observed unlicensed personnel (ULP)-E and ULP-F provide morning and incontinence cares. R1 was observed to reposition side to side placing pressure on the bedrails. The bedrails appeared to be a bit wobbly. R1's diagnoses included dementia, diabetes, and sleep apnea (a potentially serious sleep disorder in which breathing repeatedly stops and starts). R1's service plan dated July 12, 2022, indicated the resident received the following services:	02310		

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	31767	A. BUILDING: _____ B. WING _____	09/14/2022

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02310	Continued From page 28 medication administration, assistance with transferring, toileting, dressing, grooming and blood glucose monitoring. R1's assessment dated July 26, 2022, indicated R1 had episodes of incontinence and needed assistance with bed mobility including repositioning, sitting up, and laying down. R1 was deemed a high fall risk. Under the "Safety" category of R1's assessment it indicated R1 had a hospital bed; the resident was unable to get out of bed independently; and that the bed safety zone assessment was not applicable. R1's Bed Safety Assessment dated July 26, 2022, completed by registered nurse (RN)-B indicated R1 had a hospital bed with top half rails on both sides of the bed to aide in positioning. R1's bedrails were not identified as a restraint as they were used as a turning and positioning aide. In addition, education had been provided to the resident/responsible party with regards to the risks and benefits of the bedrails. R1's record lacked a bedrail assessment which included actual measurements of the entrapment zones. R2 On September 13, 2022, at 7:41 a.m., the surveyor observed R2 laying in a hospital bed with bilateral upper loop style bedrails in the upright position. The surveyor observed ULP-G and ULP-F provide morning incontinence and grooming cares. R2 was observed to reposition from side to side with ULP-G and ULP-F's assistance when providing cares. The bedrail appeared to be securely fastened to R2's bed. R2's diagnoses included diabetes, congested	02310		

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	31767	A. BUILDING: _____ B. WING _____	09/14/2022

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02310	Continued From page 29 heart failure, atrial fibrillation (irregular often rapid heart rate), and cerebrovascular accident (CVA-stroke). R2's service plan dated July 20, 2022, indicated the resident received the following services: medication administration, assistance with dressing, bathing, transferring, repositioning, toileting, and blood glucose monitoring. R2's Grab Bar/Side Rail Safety acknowledgement form dated July 22, 2022, was signed by R2's responsible party to acknowledge receipt that they had received "A Guide to Bed Safety" which includes the risks and benefits of bedrails. R2's assessment dated August 3, 2022, indicated R2 required assistance of two people and a mechanical lift for transferring and was incontinent of bowel and bladder. Under the "Safety" category of R2's assessment it indicated R2 had a hospital bed with a grab bar to aid the resident with repositioning and turning. R2's Bed Safety Assessment dated August 3, 2022, completed by RN-B indicated R2 had a hospital bed with grab bars to aide in repositioning and turning. R2's record lacked a bedrail assessment which included actual measurements of the entrapment zones. R3 On September 13, 2022, at 8:28 a.m., the surveyor observed R3 laying in a hospital bed with bilateral upper loop shaped bedrails in the upright position. The surveyor observed ULP-E to assist R3 out of bed and provided morning cares. The bedrails on R3's bed appeared to be securely	02310		

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02310	Continued From page 30 fastened to the bed when pressure was placed on them by R3. R3's diagnoses included diabetes, depression, hypertension, arthritis, and chronic obstructive pulmonary disease (COPD). R3's service plan dated May 3, 2022, indicated the resident received the following services: medication administration, assistance with bathing, dressing, grooming, toileting, and blood glucose monitoring. In addition, the Guide to Bed Safety Brochure had been provided outlining the risk and benefits of bedrails. R3's Assessment and Bed Safety Assessment completed by RN-B and dated September 8, 2022, indicted R3 required assistance of one with transferring and bed mobility including sitting up. Under the "Safety" category of R3's assessment it indicated R3 had a hospital bed with bilateral side loop bars. R3's record lacked a bedrail assessment which included actual measurements of the entrapment zones. On September 13, 2022, at 10:55 a.m., RN-B stated the bedrail assessments were completed each time the 90-day assessments were completed. RN-B stated she was aware of the zones of entrapment, however, measuring the zones was not part of her assessment. RN-B stated when she does complete a bedrail assessment, she does physically assess the bedrail to assure it is securely fastened to the bed. On September 13, 2022, at 11:07 a.m., RN-B measured R1's bedrails with the surveyor	02310		

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02310	Continued From page 31 present. Zone 1 measured 4 inches tall and 25 inches wide, which is compliant with the FDA guidelines. RN-B placed pressure on R1's bedrails and stated they were a bit loose. On September 13, 2022, at 11:11 a.m., RN-B measured R3's bedrails with the surveyor present. Zone 1 measured 7 ¾ inches tall and 4 ¾ inches wide, which is complaint with FDA guidelines. RN-B placed pressure on R3's bedrail and found them to be securely fastened to the bed. On September 13, 2022, at 11:17 a.m., RN-B measured R2's bedrails with the surveyor present. Zone 1 measured 3 ¾'s inches tall and 6 ¼ inches wide, which is complaint with FDA guidelines. RN-B placed pressure on R2's bedrail and found them to be securely fastened to the bed. The licensee's Siderail policy dated April 29, 2019, indicted when siderails are used the RN would conduct an assessment to identify the intended purpose of the siderail and the risks regarding the use of the siderail. Staff from the facility shall determine if the siderail is considered to be safe. "Safe" shall be defined as the siderail design is consistent with the FDA's 2006 recommended dimensional measurements to reduce entrapment. This means siderail zones 1, 2, and 3 must not exceed 4.75 inches. Zone 3 must not exceed 2.375 inches. The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (space between the rails), should be less than 4 and 3/4 inches.	02310		

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02310	Continued From page 32 The FDA "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe". No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE On September 13, 2022, at 4:41 p.m., the immediacy of correction order 2310 was removed, however non-compliance remained at a level three widespread scope (I). TIME PERIOD FOR CORRECTION: Seven (7) days	02310		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors 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.	03090		

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03090	Continued From page 33 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure signage was posted at the main entryway of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all 26 residents, staff, and visitors 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 the potential to affect a large portion or all the residents). The findings include: On September 12, 2022, at 9:30 a.m., the surveyor entered the facility. Signage posted to the left of the main entrance door indicated, "Security Alert - 24-hour video surveillance - all activities are monitored and recorded". On September 12, 2022, at 10:50 a.m., licensed assisted living director (LALD)-A stated the facility had six or seven video cameras located around the parameter of the outside of the building and in the hallways. LALD-A confirmed the electronic monitoring signage posted did not include the statutory language as required. LALD-A stated she thought they used to have a sign posted with this language, but it must have been taken down. The licensee's Electronic Monitoring policy dated January 10, 2022, noted signs would be installed at each facility entrance accessible to visitors that state: "Electronic monitoring devices, including	03090		

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HILLCREST SENIOR LIVING	311 BROADWAY AVENUE NE RED LAKE FALLS, MN 56750

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03090	Continued From page 34 security cameras and audio devices, may be present to record persons or activities". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

DEPARTMENT OF HEALTH

Type: Full
Date: *09/12/22*
Time: 11:47:39
Report: 8045221095

Food and Beverage Establishment Inspection Report

Location:
Hillcrest Senior Living
311 Broadway Avenue NE
Red Lake Falls, MN56750
Red Lake County, 63

Establishment Info:
ID #: 0031250
Risk: Medium
Announced Inspection: No

License Categories:

Expires on: / /

Operator:
Hillcrest Senior Living, Inc.

Phone #: 2182532157
ID #: 43026

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.

4-300 Equipment Numbers and Capacities

4-302.14 ** Priority 2 **

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

NOT AVAILABLE AT TIME OF INSPECTION.

Comply By: 09/16/22

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

EMPLOYEE HAS COMPLETED SERVE SAFE COURSE ON 8/16/22. PENDING CFPM APPLICATION. EMPLOYEE BEYOND 60 DAYS OF EMPLOYMENT.

Comply By: 10/01/22

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200 at Degrees Fahrenheit
Location: SPRAY BOTTLE
Violation Issued: No

Hot Water: = at 160 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 38 Degrees Fahrenheit - Location: ALL ITEMS (AURORA)
Violation Issued: No

Type: Full
Date: *09/12/22*
Time: 11:47:39
Report: 8045221095
Hillcrest Senior Living

Food and Beverage Establishment Inspection Report

Process/Item: Cooking
Temperature: 210 Degrees Fahrenheit - Location: SCALLOPED POTATOES
Violation Issued: No

Process/Item: Cooking
Temperature: 210 Degrees Fahrenheit - Location: PULLED PORK
Violation Issued: No

Process/Item: Hot Holding
Temperature: 194 Degrees Fahrenheit - Location: PULLED PORK
Violation Issued: No

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

ITEMS DISCUSSED:

-PROPER HAND WASHING
-BARE HAND CONTACT
-EMPLOYEE ILLNESS

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

I acknowledge receipt of the inspection report number 8045221095 of 09/12/22.

Certified Food Protection Manager: PENDING

Certification Number: _____ Expires: / /

Signed: _____
Establishment Representative

Signed: Adam J. Bommersbach

Adam Bommersbach
Public Health Sanitarian
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adam.bommersbach@state.mn.us