Electronically Delivered

May 24, 2024

Licensee
Brandon's Assisted Living
305 Central Avenue South
Brandon, MN 56315

RE: Project Number(s) SL30742015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 17, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

The correction order documentation should include the following:

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

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30742	A. BUILDING: _____ B. WING _____	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON'S ASSISTED LIVING	305 CENTRAL AVENUE SOUTH BRANDON, MN 56315

(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: SL30742015 On May 13, 2024, through May 14, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were nine (9) residents receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care 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 SUBDIVISION 11 (b)(1)(2).	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated May 14, 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		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control	0 660		

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0 660	Continued From page 2 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 Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which includes documentation of completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for one of one employee unlicensed personnel (ULP)-B. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	0 660		

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0 660	Continued From page 3 The licensee's TB facility risk assessment, dated January 2, 2024, indicated the facility was low risk for TB. ULP-B began providing direct care services for the licensee on February 10, 2021. ULP-B employee record included a Baseline TB screening tool for Health Care Workers (HCWs), dated May 3, 2022; 447 days after date of hire. ULP'-B's employee record included a second step of a two-step TST, dated May 20, 2022; 464 days after date of hire. On May 14, 2024, at 1:00 p.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A verified ULP-B completed the first step of a two-step TST on May 20, 2022. LALD/LPN stated ULP-B had lacked a two-step TST upon hire and performed the TST after an audit was performed. The licensee's 8.16 Infection Control policy dated August 1, 2021, indicated staff whose job function require work within the same air space of residents would be screened and tested for tuberculosis prior to the staff being exposed to residents. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and the CDC guidelines, indicated a TB infection control program should include a facility TB risk assessment. The guidelines also 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 IGRA (serum blood test) or TST (first	0 660		

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0 660	Continued From page 4 step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at	0 810		

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0 810	Continued From page 5 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 a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On May 14, 2024, at 2:10 p.m., licensed assisted living director/licensed practical Nurse (LALD/LPN)-A and maintenance director (MD)-D provided documents on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the current emergency evacuation map was not up to date. The current map did not show a new laundry room and resident room #116 was shown in two different	0 810		

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0 810	Continued From page 6 places. Record review of the available documentation indicated that the licensee did not have complete employee actions to be taken in the event of a fire or similar emergency as well as complete procedures for residents' movement, evacuation, and relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. 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	0 970		

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0 970	Continued From page 7 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: During the entrance conference on May 13, 2024, at 9:30 a.m., the surveyor asked for a copy of the licensee's assisted living contract. The assisted living contract was provided and later reviewed by the surveyor. The (facility name) Assisted Living Contract included a clause on page 14 section two (2) read: resident will indemnify and hold harmless provider, its employees and agents form and against all claims, actions, damages, and liability and expense in connection with loss of life, personal injury or damage of property. Also, Section four (4) read: Provider is not liable to resident or residents' guest for any injury, death or property damage occurring in the apartment unit or on provider's premises. On May 13, 2024, at 1:22 p.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A clinical stated the licensee provided the same assisted living contract to all residents and a waiver of liability was written in the assisted living contract. LALD/LPN-A further stated the licensee was not aware of a waiver of liability. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		

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01440	Continued From page 8	01440		
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 a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for one of one employee (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01440		

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01440	Continued From page 9 cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-B began employment on February 10, 2021. ULP-B's employee record lacked documentation of direct supervision of performing a delegated task within 30 days of providing services to verify the work was performed competently and to identify problems and solutions to address issues relating to the staff's ability to provide the services. On May 14, 2024, at 10:22 a.m., the surveyor observed ULP-B perform morning medication administration, insulin administration, eye drops, application of prescription cream, compression stockings, and blood glucose check. On May 14, 2024, at 1:00 p.m. licensed assisted living director/licensed practical nurse (LALD/LPN)-A verified they did not have a 30-day supervision for ULP-B. LALD/LPN-A stated the previous registered nurse completed the 30-day supervision on paper and lacked the completed supervision on ULP-B's employee record upon audit. The licensee's 6.17 Supervision of Staff Delegated Services policy dated August 1, 2021; indicated direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for licensee. No further information was provided.	01440		

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01440	Continued From page 10 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were labeled maintained bearing legible information for three of four (R1, R5, R6) residents and including the opened-on date for time sensitive medication for two of four residents (R1, R5). In addition, the licensee failed to monitor for expired stock medications in two of four residents (R4, R5) medication storage cabinet. 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:	01890		

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01890	Continued From page 11 During the entrance conference on May 13, 2024, at 9:30 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated the licensee provided medication management services to residents at the facility. On May 13, 2024, at 10:40 a.m. the surveyor reviewed the medication cart with LALD/LPN-A and unlicensed personnel (ULP)-B. LABLED -R1's opened Flonase (nasal spray used to reduced inflammation and allergic symptoms) lacked a label with resident's name and prescription label. -R5's opened Fluticasone (nasal spray used to reduce inflammations) lacked a label with resident's name and prescription label. -R6's opened Novolog (insulin pen used to treat diabetes in managing blood sugar levels) lacked a label with resident's name and prescription label. TIME SENSITIVE MEDICATION - R1's opened Flonase (nasal spray used to reduced inflammation and allergic symptoms) lacked the date the bottle was opened and when the medication would expire. - R5's opened Fluticasone (nasal spray used to reduce inflammations) lacked the date the bottle was opened and when the medication would expire. EXPIRED MEDICATION -R4's opened Albuterol inhaler (assist in opening medium and large airways in the lungs) had an expiration dated April 26, 2024. -R5's opened Triamcinolone cream (use to treat certain skin diseases) had an expiration dated April 21, 2024.	01890		

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01890	Continued From page 12 On May 13, 2024, at 10:45 a.m., ULP-B stated resident's labels do frequently fall off in the medication cart and when found staff tape the label of the medication back onto the medication. ULP-B stated that open dates are placed on all time sensitive medication with a cheat sheet placed by the medication cart for the staff to be reviewed when placing the open and expiration date on the medications and was unsure why they were lacking the information needed. ULP-B stated expired medication should be removed from the medication cart and disposed of. On May 14, 2024, at 9:42 a.m., clinical nurse supervisor (CNS)-C stated that CNS-C oversees going through the medication cart and disposes expired medications. CNS-C stated they were uncertain why the medications were missed. The licensee's 7.13 Medications Prescription Drug policy dated August 1, 2021, indicated the prescription drug must be kept in the original container and bear the original prescription label including the expiration or beyond use date. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02310 SS=F	144G.91 Subd. 4 (a) 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30742	A. BUILDING: _____ B. WING _____	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON'S ASSISTED LIVING	305 CENTRAL AVENUE SOUTH BRANDON, MN 56315

(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
02310	Continued From page 13 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards related to oxygen storage. 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: On May 13, 2024, at 10:30 p.m., survey staff toured the facility with licensed assisted living director/licensed practical nurse (LALD/LPN)-A and unlicensed personnel (ULP)-B. During the tour, survey staff observed oxygen cylinders improperly stored in the medication room. Oxygen cylinders must be stored securely in areas designated for that use. The medication room contained one large cylinder and three little cylinders unsecured loosely stored on the shelve in the medication room and not placed in the rack next to the loosely stored oxygen cylinders. Oxygen cylinders must be stored upright and firmly secured to prevent them from falling or being knocked over. During the facility tour interview, LALD/LPN-A and ULP-B stated they did not know why these oxygen cylinders were not stored securely.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30742	A. BUILDING: _____ B. WING _____	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON'S ASSISTED LIVING	305 CENTRAL AVENUE SOUTH BRANDON, MN 56315

(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
02310	Continued From page 14 On May 14, 2024, at 9:42 a.m. clinical nurse supervisor (CNS)- C stated they were unaware that oxygen cylinders must be stored upright and firmly secured to prevent them from falling or being knocked over. The licensee's 7.40 Oxygen policy dated August 1, 2021, indicated oxygen cylinders would be stored in an appropriate storage rack and must remain upright at all times. Minnesota Department of Health's Oxygen Cylinder Storage Requirements document dated April 16, 2020, noted the cylinders must be secured with chains or racks. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

Minnesota Department of Health
Fergus Falls District
2312 College Way
Fergus Falls
218-332-5150

Type: Full
Date: *05/14/24*
Time: 11:00:00
Report: 1049241085

Food and Beverage Establishment Inspection Report

Location:
Brandon'S Assisted Living
305 Central Avenue South
Brandon, MN56315
Douglas County, 21

Establishment Info:
ID #: 0038944
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3205242207
ID #:

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

The following orders were issued during this inspection.

3-500D Microbial Control: disposition of food

3-501.18A ***** Priority 1 *****

MN Rule 4626.0405A Discard all TCS food prepared in the establishment or opened commercially packaged food when the time exceeds 7 days from the preparation or opening date or if the container or package is not marked.

THERE WERE TWO BAGS OF RAW BACON IN THE KITCHEN UPRIGHT COOLER THAT WERE DATE MARKED 5/1/2024. PIC DISCARDED THE RAW BACON DURING THE INSPECTION. VIOLATION CORRECTED ON SITE.

Corrected on Site

4-600 Cleaning Equipment and Utensils

4-601.11C

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

THE KITCHEN STOVE RACKS AND BOTTOM OF EACH COOKING COMPARTMENT HAD AN ACCUMULATION OF FOOD DEBRIS. THE PIC IS INSTRUCTED TO CLEAN THE STOVE ACCORDINGLY.

Comply By: 05/15/24

Surface and Equipment Sanitizers

Hot Water: = at 174 Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

Food and Equipment Temperatures

Food and Beverage Establishment Inspection Report

Process/Item: Upright Cooler
Temperature: 32 Degrees Fahrenheit - Location: Kitchen - Yogurt
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 23 Degrees Fahrenheit - Location: Kitchen - Jello
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 30 Degrees Fahrenheit - Location: Kitchen - Orange Juice
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 30 Degrees Fahrenheit - Location: Storage Room - Cream Cheese
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 35 Degrees Fahrenheit - Location: Storage Room - Lettuce
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 23 Degrees Fahrenheit - Location: Storage Room - Milk
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 35 Degrees Fahrenheit - Location: Storage Room - Ground Meat
Violation Issued: No

Process/Item: Cooking
Temperature: 146.5 Degrees Fahrenheit - Location: Beef Stew
Violation Issued: No

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

THE INSPECTOR MET WITH THE ESTABLISHMENT REPRESENTATIVE, MELISSA ENGLUND, AND NURSE EVALUATOR, JESSICA DETERS.

KITCHEN HAS LAMINATE FLOORING, WOOD CABINETS WITH LAMINATE COUNTERTOPS, STAINLESS STEEL TWO COMPARTMENT SINK AND HANDWASHING SINK, TILE ON THE WALLS BEHIND THE EQUIPMENT, AND A SMOOTH CEILING.

THE INSPECTOR PROVIDED THE SUSCEPTIBLE POPULATION PDF TO THE ESTABLISHMENT REPRESENTATIVE.

DISHWASHER HAS A SANITIZER CYCLE AND REACHES THE CORRECT TEMPERATURE AS REQUIRED BY CODE.

Type: Full
Date: *05/14/24*
Time: 11:00:00
Report: 1049241085
Brandon'S Assisted Living

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1049241085 of 05/14/24.

Certified Food Protection Manager: Melissa Englund

Certification Number: FM89948 Expires: 07/16/26

Signed: _____

Establishment Representative

Signed: *Stephanie Reynolds*

Stephanie Reynolds
Public Health Sanitarian
Fergus Falls
218-332-5179
stephanie.reynolds@state.mn.us

Report #: 1049241085

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Fergus Falls District
2312 College Way
Fergus Falls

No. of RF/PHI Categories Out	1
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 05/14/24
Time In 11:00:00
Time Out

Brandon'S Assisted Living	Address: 305 Central Avenue South	City/State: Brandon, MN	Zip Code: 56315	Telephone: 3205242207
License/Permit #: 0038944	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
Supervision				
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	X	
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		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	X	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:** 05/15/24

Inspector (Signature) Stephanie Reynolds