Electronically Delivered

April 28, 2025

Licensee
Ashby Living Center
112 Iverson Avenue
Ashby, MN 56309

RE: Project Number(s) SL33447016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 1, 2025, 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,

Jessie Chenze

Jessie Chenze, Supervisor
State Evaluation Team
Email: Jessie.Chenze@state.mn.us
Telephone: 218-332-5175 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
	33447	A. BUILDING: _____ B. WING _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHBY LIVING CENTER	112 IVERSON AVENUE ASHBY, MN 56309

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0 000	Initial Comments 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: SL33447016-0 On March 31, 2025, through April 1, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 16 residents; 16 receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been 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 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 evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 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 observation, interview, and record review, the licensee failed to ensure the licensee's Direct-Care Staffing Plan was evaluated at least twice a year, of the appropriateness of staffing levels in the facility. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 470		

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0 470	Continued From page 2 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 license with dementia care. The facility was licensed for a capacity of twenty-four and had a current census of sixteen residents. During the entrance conference on March 31, 2025, at 9:15 a.m., licensed assisted living director (LALD)-A stated the licensee was familiar with current minimum assisted living requirements. On April 1, 2025, at 12:03 p.m., LALD-A stated the licensee developed and implemented a written staffing plan, however, lacked documentation the staffing plan had been reviewed at least twice a year. LALD-A stated the staffing plan has been talked about in monthly meetings, however not documented, and was unaware of this requirement. The licensee's Staffing, Direct-Care Staffing Plan and Daily schedule policy reviewed on March 6, 2025, indicated the staffing plan would be evaluated for the appropriate staffing levels in the facility and revised as needed at a minimum of two times a year. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 470		

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0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts	0 480		

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0 480	Continued From page 4 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. 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, 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated March 31, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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0 480	Continued From page 5 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 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 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 TB education on hire for one of two employees (clinical nurse supervisor (CNS)-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	0 660		

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0 660	Continued From page 6 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: CNS-B was hired on February 1, 2024, to provide supervision and oversite to unlicensed personnel and to provide direct care services under the assisted living license. CNS-B's record lacked TB education, to include, TB signs and symptoms, a review of the licensee's infection control plan and other communicable diseases (completed April 1, 2025, after surveyor entered on March 31, 2025). On April 1, 2025, at 9:30 a.m., CNS-B stated she did not complete her orientation training. CNS-B stated when she initially started her position with the licensee, CNS-B had taken time off for personal reasons, and when she returned, CNS-B forgot about the rest of the training as she had other responsibilities that needed to be completed. The licensee's 8.0 TB Prevention and Control policy reviewed March 6, 2025, indicated the nurse is responsible for establishing and maintaining the TB preventions and control program. Responsibilities include education of assisted living staff, regarding TB signs and symptoms, our infection control plan and other communicable diseases No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 660		

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0 660	Continued From page 7 (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the required content and failed to review the missing resident policy quarterly. This had the potential to affect all residents, staff, and visitors of the facility.	0 680		

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0 680	Continued From page 8 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's Emergency Preparedness Manual dated March 7, 2025, included a fire, flooding, severe weather/tornado warning plans, evacuation, shelter in place, and a missing resident plan and diagrams of the facility. The licensee's plan lacked the following content and/or policies and procedures to address: - the development of arrangements with other facilities and providers to receive residents if needed; - the facilities role in providing care and treatment at alternative sites; - the provision of subsistence needs for staff and residents; - a tracking system used to document locations of residents and staff; and - the medical record documentation system the facility has developed to preserve resident information security and availability of records. In addition, the licensee lacked a communication plan that included: - names and contact information for staff, entities providing services under arrangement, resident physicians, other facilities, and volunteers; - contact information for federal, state, tribal, ombudsman, state licensing and certification	0 680		

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0 680	Continued From page 9 agencies; - primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management agencies; - a method of sharing information and medical documentation for residents; and - a method of sharing information from the emergency plan with residents and their families. On April 1, 2025, at 12:15 p.m., licensed assisted living director (LALD)-A stated LALD-A had completed the EPP, however was unable to locate the missing information. LALD-A stated LALD-A was unaware the missing resident policy needed to be reviewed quarterly. The licensee's Emergency Preparedness policy dated November 12, 2024, indicated it is the policy of [facility] to comply with all Federal, State, and local laws regarding community emergency preparedness and to maintain an emergency preparedness program with 144G.42 emergency preparedness. [Facility] will work to achieve full compliance by the effective date of August 1, 2021. The licensee's Missing Resident policy reviewed March 6, 2025, indicated the LALD and clinical nurse supervisor (CNS) will review the missing resident plan at least quarterly and document any changes to the plan. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0110, Subp. 4, effective October 2022, the assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan.	0 680		

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0 680	Continued From page 10 Per Assisted Living Facilities: Minnesota Rules Chapter 4695, 4659.0100, sections A and B, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or	0 730		

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0 730	Continued From page 11 conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included a discharge summary with the required content for one of one resident, (R2) discharged from the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	0 730		

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0 730	Continued From page 12 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 licensee's Discharge Resident Roster dated November 20, 2024, (roster was updated March 31, 2025, on surveyor arrival), indicated R2 was admitted to the facility on January 16, 2023, and was discharged on December 9, 2024. R2's diagnoses included atrial fibrillation (irregular heartbeat) and hypertension (high blood pressure). R2's progress note dated December 9, 2024, at 6:16 p.m., written by administration assistant (AA)-D, indicated R2 was transported to [facility name] by R2's daughter around 10:00 a.m. R2's medication and paperwork was sent with her family. Family was packing up her room and moving. R2's record lacked a discharge summary. On April 1, 2025, at 9:45 a.m., clinical nurse supervisor (CNS)-B stated she did not complete a discharge summary for R2. CNS-B stated she was unfamiliar with the discharge process. The licensee's Discharge Summary policy reviewed on March 6, 2025, indicated a discharge summary will be written by the time of discharge (sic). Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0120, Subp. 9, effective October	0 730		

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	33447	A. BUILDING: _____ B. WING _____	04/01/2025

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0 730	Continued From page 13 2022, at the time of discharge, the facility must provide the resident, and, with the resident's consent, the resident's representatives, and case manager, with a written discharge summary that includes all content as applicable in sections A.-D. A. A summary of the residents stay that included diagnoses, courses of illnesses, allergies, treatments, and therapies, and pertinent lab, radiology, and consultation results; B. A final summary of the resident's status from the latest assessment or review under Minnesota Statutes, section 144G.70, if applicable, which included the resident status, including baseline and current mental, behavioral, and functional status; C. A reconciliation of all predischarge medications with the resident's post discharge prescribed and over-the-counter medications; and D. A post discharge care plan that was developed with the resident and, with the resident's consent, the resident's representatives, which would help the resident adjust to a new living environment. The post discharge care plan must indicate where the resident planned to reside, any arrangements that had been made for the resident's follow-up care, and any post discharge medical and nonmedical services the resident would need. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and	0 810		

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0 810	Continued From page 14 maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff 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) Staff 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 least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors.	0 810		

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0 810	Continued From page 15 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On April 1, 2025, at 1:45 p.m., administrative assistant (AA)-D provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The FSEP (fire safety and evacuation plan) included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) and was very basic. The provided FSEP was a general guidance for fire response including responding to a fire alarm, activating the RACE but did not provide specific employee and resident actions to take in the event of a fire or similar emergency geared to this facility. AA-D failed to provide the FSEP (fire safety and evacuation plan) for employee procedures and specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks.	0 810		

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0 810	Continued From page 16 Survey staff reviewed the fire evacuation diagrams and observed that the resident rooms were not clearly labeled. Exit plan diagrams must be correctly labeled to reduce confusion and potential obstructions to egress in a fire or similar emergency. AA-D stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01290 SS=D	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study	01290		

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01290	Continued From page 17 (BGS) was submitted and a clearance received for one of one employee (cook (C)-F). This had the potential to affect all 16 residents. 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: During the entrance conference on March 31, 2025, at 9:15 a.m., licensed assisted living director (LALD)-A stated LALD-A was aware of the required content of the employee record. The licensee's undated Employee Roster listed C-F as a current employee of the licensee. C-F was hired on November 18, 2024, to provide indirect care to the residents of the licensee. The Department of Human Services (DHS) Net Study 2.0 employee roster dated March 31, 2025, did not include C-F as a current employee of the licensee. C-F's timecard from March 1, 2025, through March 29, 2025, indicated C-F worked 92.17 hours during this time frame. On March 31, 2025, at 1:34 p.m., administrative assistant (AA)-D stated C-F had never worked alone and has always been supervised since hire date. AA-D, LALD-A and surveyor reviewed	01290		

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01290	Continued From page 18 March 2024 timecards, which showed evidence, C-F had been supervised during C-F's shift. LALD-A stated background checks are completed on all new hires and was unsure why C-F's background study was missed. The licensee's Background Checks policy dated March 6, 2025, indicated all employees, as well as contractors, and regularly scheduled volunteers of the facility with direct resident contact will undergo a background study through Department of Human Service (DHS). Only those with satisfactory results will continue to work with the facility and its residents. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
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	01470		

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01470	Continued From page 19 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 staff member 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 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.	01470		

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01470	Continued From page 20 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 two employees, clinical nurse supervisor (CNS)-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: CNS-B was hired on February 1, 2024, to provide supervision and oversite to unlicensed personnel and to provide direct care services under the assisted living license. CNS-B's employee record included a transcript from Educare (on-line training), indicating CNS-B completed orientation in Assisted Living Bill of Rights. However, CNS-B's record lacked evidence of completing the following assisted living orientation 144G requirement topics before providing assisted living services to the licensee's residents: -an overview of this chapter 144G (completed April 1, 2025, after surveyor entered on March 31, 2025); -compliance with and reporting of the maltreatment of vulnerable adults under section	01470		

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01470	Continued From page 21 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; -handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; and -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. On April 1, 2025, at 9:30 a.m., CNS-B stated she did not complete her orientation training. CNS-B stated when she initially started her position with the licensee, CNS-B had taken time off for personal reasons, and when she returned, CNS-B forgot about the rest of the training as she had other responsibilities that needed to be completed. The licensee's Assisted Living & Assisted Living with Memory Care Orientation-All Staff policy reviewed March 6, 2025, indicated all assisted living employees must complete an orientation to assisted living facility requirements and regulations before providing services to residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		

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01540	Continued From page 22	01540		
01540 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees providing direct care received at least eight hours of dementia training within 80 hours of start date for one of two employees (clinical nurse supervisor (CNS)-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).	01540		

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01540	Continued From page 23 The findings include: CNS-B was hired on February 1, 2024, to provide supervision and oversite to unlicensed personnel and to provide direct care services under the assisted living license. CNS-B's employee record included a transcript from Educare (on-line training) indicated CNS-B completed six hours of dementia training, falling short by two hours for the eight-hour requirement. On April 1, 2025, at 9:30 a.m., CNS-B stated she did not complete her orientation training, including the 8 hours of dementia training. CNS-B stated when she initially started her position with the licensee, CNS-B had taken time off for personal reasons, and when she returned, CNS-B forgot about the rest of the training as she had other responsibilities that needed to be completed. On April 1, 2025, at 12:05 p.m., licensed assisted living director (LALD)-A stated CNS-B had worked over 80 hours since CNS-B's hire date. The licensee's Dementia Training policy reviewed March 6, 2025, indicated orientation for direct-care staff in assisted living with dementia care licensed settings will complete a minimum of eight hours of initial training on dementia care topics. Initial training will be completed within 80 hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01540		

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01620	Continued From page 24	01620		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed ongoing assessments not to exceed 90-calendar days from the last assessment for three of three residents (R1, R3, R9). 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	01620		

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01620	Continued From page 25 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: During the entrance conference on March 31, 2025, at 9:15 a.m., licensed assisted living director (LALD)-A stated the RN completes pre-admission assessment, a 14-day assessment, ongoing assessments every 90 days and change of condition assessments would be conducted on residents for instances such as change in services, or a change in condition. R1 R1's diagnoses included diabetes and renal insufficiency (decreased kidney function). R1's service plan revised on February 22, 2025, indicated R1 received medication administration, incontinence cares, assistance with bathing, hearing aids, dressing, weekly vital signs, laundry and housekeeping. R1's records indicated 90-day assessments were completed on November 21, 2024, and March 19, 2025, which exceeded the 90 days from the last assessment (118 days in between assessments). R3 R3's diagnoses included heart failure and hyperlipidemia (high cholesterol). R3's service plan revised on February 20, 2025, indicated R3 received medication administration, laundry, and housekeeping.	01620		

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01620	Continued From page 26 R3's record indicated R3's last 90-day assessment were completed on December 30, 2024, and at exit of survey date April 1, 2024, exceeded the 90 days from the last assessment (92 days). R9 R9's diagnoses included heart disease and gastritis (inflammation or irritation of the stomach lining). R9's service plan revised on February 21, 2025, indicated R9 received medication administration, assistance with bathing, compression stockings, bed making, weekly vital signs, laundry, and housekeeping. R9's record indicated R9's last 90-day assessment was completed on December 15, 2024, and at exit of survey date April 1, 2024, exceeded the 90 days from the last assessment (107 days). On April 1, 2025, at 2:00 p.m., clinical nurse supervisor (CNS)-B stated R1's 90-day assessment was completed on time, CNS-B stated CNS-B forgot to sign and close it on the day it was completed. CNS-B stated R3 and R9's 90-day assessments were late. CNS-B stated CNS-B recently set up the electronic medication record (EMR) to notify when the residents 90-day assessments are due. The licensee's 5.0 Initial and On-Going Assessment of Residents policy reviewed March 6, 2025, indicated the RN will complete the following comprehensive assessment will be completed periodically but no less than every 90 days.	01620		

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01620	Continued From page 27 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01790 SS=D	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's	01790		

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01790	Continued From page 28 medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one unlicensed personnel (ULP-E) was trained by registered nurse (RN) and had demonstrated competency to prepare and give medications for residents having unplanned time away. 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	01790		

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01790	Continued From page 29 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-E was hired on June 26, 2020, and began to provide direct care services to residents of the facility on August 1, 2021. On March 31, 2025, at 11:42 a.m., the surveyor observed ULP-E administer R1's noon insulin. ULP-E's employee record lacked evidence to indicate ULP-E had demonstrated competency to provide medications to residents for unplanned times away from home. On April 1, 2025, at 10:07 a.m., ULP-E stated the nurses set up medications for residents who leave the facility during the day. ULP-E stated she has not been trained to set up medications for unplanned times away, however stated she could figure it out. On April 1, 2025, at 1:40 p.m., clinical nurse supervisor (CNS)-B stated she was unsure if ULP-E was trained for residents having unplanned times away. CNS-B stated the nurse before her would have trained her. On April 2, 2025, at 1:06 p.m., the surveyor received an email (electronic mail) from licensed assisted living director (LALD)-A with the licensee's leave of absence (LOA) medication directions form. The form did not indicate when the ULP would be trained or how it was	01790		

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01790	Continued From page 30 determined the ULP was competent to follow the correct procedures for giving medications to residents. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01880 SS=F	144G.71 Subd. 19 Storage of medications 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 interview and record review, the licensee failed to ensure refrigerated medication were maintained at manufacturer recommended temperatures by failing to monitor and document medication refrigerator temperatures for one of one medication refrigerators. 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: During the entrance conference on March 31,	01880		

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01880	Continued From page 31 2025, at 9:15 a.m., licensed assisted living director (LALD)-A stated the licensee provided medication management services to the residents at the facility. On March 31, 2025, at 11:00 a.m., the surveyor observed the secured medication refrigerator inside the nurse office. Unlicensed personnel (ULP)-E verified the temperature of 46 degrees Fahrenheit (F). ULP-E verified the following unopened insulins (to treat high blood glucose levels) stored inside the refrigerator: -twenty-eight Novolog 100 units/milliliter (ml) pens for R1; -sixteen Lantus 100 units/ml pens for R8; and -three Toujeo 300 units/ml insulin pens and five Lantus insulin pens for R5. On April 1, 2025, at 10:50 a.m., LALD-A stated staff should be recording medication refrigerator temperatures daily. LALD-A stated the only temperature logs located were from 2022. Additionally, LALD stated the licensee switched to a new electronic health system program and was thinking the temperatures were never re-implemented. The manufacturer instructions for Novolog insulin pens dated October 2021, indicated to keep new Novolog insulin pens in the refrigerator between 36 to 46 degrees F. Do not freeze. The manufacturer's instructions for Lantus Solostar insulin pen dated June 2022, indicated to keep new Lantus insulin pens in the refrigerator between 36 to 46 degrees F. Do not freeze The manufacturer instructions for Toujeo insulin pen dated November 2019, indicated to keep new Toujeo pens in the refrigerator between 36 to 46	01880		

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01880	Continued From page 32 degrees F. Do not freeze. The licensee's 8.0 Storage of Medications policy, reviewed March 6, 2025, indicated in the clients individualized medication management plan, the registered nurse (RN) may identify the need of secured storage of the medications within the clients private living space because of cognitive status and concerns about medication diversion or other concerns. When secured storage of medication is necessary, the RN will identify where the medications will be stored, how they will be secured or locked under proper temperature controls and who has access to the medications No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=F	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 interview and record review, the licensee failed to ensure medications were maintained bearing the original prescription label with legible information including the expiration date for time sensitive medications and failed to monitor for expired medications for one of one	01890		

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01890	Continued From page 33 medication storage cart. 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 March 31, 2025, at 10:40 a.m., licensed practical nurse (LPN)-C stated time sensitive medications should be labeled with open and expiration dates and expired medications should be given to the nurse and reordered. The surveyor and LPN-C observed the medication cart and confirmed the following: TIME SENSITIVE MEDICATIONS -two opened Lantus insulin 100 units/milliliter (ml) pens (treats high blood glucose) for R1, lacked expiration dates; -one opened Latanoprost 50 micrograms (mcg) eye drops (lowers eye pressure) for R4, lacked opened and expiration dates; -opened Lantus insulin 100 units/ml and one opened glargine 300 units/ml pens for R4, lacked expiration dates; -opened budesonide/formoterol 160/4.5 mcg inhaler (treats respiratory issues) for R4, lacked opened and expiration dates; and -opened budesonide/formoterol 160/4.5 mcg inhaler for R7, lacked opened and expiration dates. EXPIRED MEDICATIONS	01890		

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01890	Continued From page 34 -nitroglycerin 0.4 ml sublingual tablets (to prevent chest pain) expired January 3, 2025 and Nystatin topical powder (for skin) expired on January 31, 2025, for R6. The manufacturer instructions for Lantus (glargine) insulin pen dated June 2022, indicated to discard after 28 days after its first use, even if it still has insulin in it. The manufacturer instructions for Latanoprost eye drops dated March 2022, indicated to discard the eye drops within four weeks of opening. The manufacturer instructions for budesonide/formoterol inhaler dated February 2009, indicated to discard the inhaler when the counter reaches zero or three months after you take the inhaler out of its foil pouch, whichever comes first. On March 31, 2025, at 10:42 a.m., unlicensed personnel (ULP)-E stated ULP-E only had written the open date on insulins, but not the expiration date, and was unaware eye drops and inhalers needed to be labeled with open and expiration dates. The licensee's 8.0 Storage of Medications policy reviewed March 6, 2025 indicated a legend drug must be kept in its original container bearing the original prescription label with legible information stating prescription number, name of drug, strength and quantity of drug, expiration date of time-dated drug, directions for use, clients name, prescriber name, date of issue and the name and address of the licensed pharmacy that issued the medications. No further information was provided.	01890		

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01890	Continued From page 35 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 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 record the disposition of medications as required for one of one resident (R2) 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) and was issued at a	01910		

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01910	Continued From page 36 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: R2's diagnoses included atrial fibrillation (irregular heartbeat) and hypertension (high blood pressure). R2's service plan dated May 30, 2024, indicated R2 received medication administration. R2's progress note dated December 9, 2024, at 6:16 p.m., written by administration assistant (AA)-D, indicated R2 was transported to [facility name] by R2's daughter around 10:00 a.m. R2's medication and paperwork was sent with her family. Family was packing up her room and moving. R2's resident record indicated R2 received the following medications: -amlodipine/benazepril 5-10 milligram(mg)tablet daily for hypertension; -digoxin 0.125 mg daily for atrial fibrillation; -dorzolamide/timolol ophthalmic solution eye drops twice daily treats eye pressure; -jantoven 2.5 mg daily for atrial fibrillation; -Jardiance 10 mg tablet daily for diabetes (high blood sugar levels); -metoprolol 50 mg tablet twice daily for hypertension; -Preservision Ared 2 softgel twice daily for supplement; -Toujeo Solostart 300 units/milliliter (ml) daily for diabetes; -vitamin C 500 mg daily for supplement; -vitamin D3 25 microgram (mcg) daily for	01910		

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01910	Continued From page 37 supplement; -acetaminophen 325 mg, two tablets every four hours as needed for osteoarthritis; -loperamide 2 mg as needed for diarrhea; -melatonin 3 mg daily as needed for insomnia; -Nystatin 100,000 unit/gram (g) twice daily as needed for fungal rash; and -ondansetron 4 mg every eight hours as needed for nausea and vomiting. R2's record lacked documentation of disposition of medications. On April 1, 2025, at 9:45 a.m., clinical nurse supervisor (CNS)-B stated she did not complete a disposition of medications for R2. CNS-B stated she was unfamiliar with the discharge process. The licensee's 2.0 Disposition or Disposal of Medication policy reviewed March 6, 2025, indicated a client's current medications that are secured or stored by our agency will be given to the client or the clients representative when the clients medication management services are terminated. Staff will document in the client's record the name of the person to whom medications were given, the time and date and the name of each medication and the amount of medication remaining. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that	02040		

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02040	Continued From page 38 has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property for the facility. This deficient practice had the ability 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). Findings include: A record review and interview were conducted on April 1, 2025, at 1:45 p.m. with administrative assistant (AA) -D on the hazard vulnerability assessment for the physical environment of the facility. Record review indicated that the licensee had not performed a hazard vulnerability assessment with risk and mitigation factors on	02040		

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02040	Continued From page 39 and around the property. During interview AA-D stated that the licensee had performed a hazard assessment for the Appendix Z requirements but had not performed a hazard vulnerability assessment for the physical environment on or around the property and did not have any mitigation factors listed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		

MN Department of Health
Food, Pools, and Lodging Services
PO Box 64975
St. Paul, MN 55164-0975
218-332-5150

Type: Full
Date: *03/31/25*
Time: 15:32:27
Report: 7935251048

Food and Beverage Establishment Inspection Report

Location:
Ashby Living Center
112 Iverson Avenue
Ashby, MN56309
Grant County, 26

Establishment Info:
ID #: 0038492
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2187472995
ID #:

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

The following orders were issued during this inspection.

3-500B Microbial Control: hot and cold holding

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

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

HOBART COOLER WAS 44-46 DEGREES. DIAL WAS ADJUSTED DURING INSPECTION TO A COLDER TEMPERATURE. MONITOR TEMP TO MAKE SURE IT GETS TO 41 OR BELOW.

Comply By: 03/31/25

2-100 Supervision

2-102.12DMN

MN Rule 4626.0033D Post the certified food protection manager certificate.

POST TERRY GROVER'S CERTIFICATE.

Comply By: 03/31/25

3-300B Protection from Contamination: cross-contamination, eggs

3-302.12

MN Rule 4626.0240 Properly label all working containers holding food or food ingredients that are removed from orginal packages with the common name of the food. Label the food in English and any other languages used by employees who handle food.

LABEL BULK FLOUR.

Comply By: 03/31/25

Surface and Equipment Sanitizers

Food and Beverage Establishment Inspection Report

Quaternary Ammonia: = 200 ppm at Degrees Fahrenheit
Location: Wiping Cloth Bucket
Violation Issued: No

Hot Water: = at 165 Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: Saturn
Violation Issued: No

Process/Item: Cold Holding
Temperature: 44 Degrees Fahrenheit - Location: Hobart
Violation Issued: Yes

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

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

I acknowledge receipt of the MN Department of Health inspection report number 7935251048 of 03/31/25.

Certified Food Protection Manager: Theresa Marie Grover

Certification Number: 8179 Expires: 06/08/25

Signed: _____
Establishment Representative

Signed: Rebecca Tonneson
Rebecca Tonneson
Public Health San Supervisor
Fergus Falls District Office
218-332-5142
rebecca.tonneson@state.mn.us