

Protecting, Maintaining and Improving the Health of All Minnesotans

February 27, 2023

Licensee Ageless Care Incorporated 702 7th Street Southwest Roseau, MN 56751

RE: Project Number(s) SL30550015

Dear Licensee:

On February 8, 2023, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the August 23, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Jessica Chenze, Supervisor Health Regulation Division State Evaluation Team 85 East Seventh Place, Suite 220 P.O. Box 3879

St. Paul, MN 55101-3879

Email: jessica.chenze@state.mn.us

Telephone: 218-332-5175 | Fax: 218-332-5196

HHH



Minnesota Department of Health Food, Pools and Lodging Services PO Box 64975 St. Paul, MN 55164-0975 651-201-4500

Type: Follow-Up
Date: 02/08/23
Time: 13:00:27
Report: 1002231025

# Food and Beverage Establishment Inspection Report

Page 1

tion <del>:</del>	

Ageless Care Incorporated 702 7th Street Sw Roseau, MN56751

Roseau County, 68

**License Categories:** 

Expires on: //

Establishment Info	<del>):</del>
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ID#: 0039095

Risk:

Announced Inspection: Yes

**Operator:** 

Phone #: 2184633695

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.

No NEW orders were issued during this inspection.

# **Surface and Equipment Sanitizers**

Utensil Surface Temp: = at 160 Degrees Fahrenheit Location: THERMOLABEL - DISH MACHINE

Violation Issued: No

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

The purpose of this visit was to conduct an additional follow up to a previous inspection that was conducted on 11/18/22. There was a delay due to the plumber/plumbing plan review process.

# Sanitarian's findings:

The new dish machine was observed to be installed and functioning properly at time of inspection. The local plumbing inspector (Brad Bail) provided written documentation of the plumbing inspection/approval. The dish machine is approved for use by this facility. The existing domestic sink is now permanently designated as the handwash sink.

#### Notes:

Please note that the establishment must monitor the utensil surface temperature using thermolabels or a dish machine thermometer to ensure proper sanitization. Please note that the dish machine must go through multiple cycles to warm up before use. Also, the MN food code requires that dish machines have automatically dispensing detergent and rinse aid. Follow manufacturer's recommendations.

Page 2

Type: Follow-Up
Date: 02/08/23
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Report: 1002231025
Ageless Care Incorporated

# 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 1002231025 of 02/08/23.

namoer	1002231023 01 02/00/23.							
Certified Food Protection ManagerShawny Elyk-Prevost								
Certification Number:	FM113549 Expires	11/01/25						
Inspection report reviewed with person in charge and emailed.								
Signed:		Signed:						
Shawny Elyk-F	Prevost	Cassandra Hua						
Owner/Operato	or	Public Health Sanitarian III						
		218-308-2142						

Cassandra.Hua@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 1, 2022

Administrator
Ageless Care Incorporated
702 7th Street Southwest
Roseau, MN 56751

RE: Project Number(s) SL30550015

Dear Administrator:

On November 18, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on August 23, 2022. This follow-up evaluation determined your facility had not corrected all of the state licensing orders issued pursuant to the August 23, 2022 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on August 23, 2022, found not corrected at the time of the November 18, 2022, follow-up evaluation and/or subject to penalty assessment are as follows:

# 0480-Minimum Requirements-144g.41 Subd 1 (13) (i) (b) = \$500

The details of the violations noted at the time of this follow-up evaluation completed on November 18, 2022 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the total amount you are assessed is \$500. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

# **DOCUMENTATION OF ACTION TO COMPLY**

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order by the correction order date. The commissioner may request a copy of this documentation and the assisted living facility's action to respond to the correction orders in future evaluations, upon a complaint investigation, and as otherwise needed.

#### **IMPOSITION OF FINES:**

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in §144G.20 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism

Ageless Care Incorporated December 1, 2022 Page 2

authorized in §144G.20.

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in §144G.20.

#### CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you have one opportunity to challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. This written request must be received by the Department of Health within 15 calendar days of the correction order receipt date. Please send your written request via email to the following:

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

#### **REQUESTING A HEARING**

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to Health.HRD.Appeals@state.mn.us.

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

We urge you to review these orders carefully. If you have questions, please contact me at 218-332-5175.

Ageless Care Incorporated December 1, 2022 Page 3

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Sincerely,

Jessie Chenze, RN, BSN

Supervisor 1 | State Evaluations Team Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 3879

St. Paul, MN 55101-3879

Office: 218-332-5175 | Mobile: 651-508-2791 | Fax: 218-332-5196

PMB

Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		30550	B. WING		R <b>11/18/2022</b>
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	
AGELES	S CARE INCORPORA	TFD	MN 56751		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
{0 000}	Initial Comments		{0 000}		
	In accordance with 144G.08 to 144G.9 been issued pursual Determination of whom corrected requires or requirements provide indicated below. Whom contains several ite of the items will be compliance.  INITIAL COMMENT Project SL3055001  On November 18, 2 Department of Heal above provider to for pursuant to a survey 2022. At the time or residents: 18 receivers a survey to the interest of the items will be compliance.	PROVIDER LICENSING DER  Minnesota Statutes, section 5 this correction order(s) has ant to a survey.  The ther a violation has been compliance with all ded at the Statute number then Minnesota Statute ms, failure to comply with any considered lack of  TS: 5-1  2022, the Minnesota Ith conducted a revisit at the follow-up on orders issued by completed on August 23, of the survey, there were 20 fring services under the finese. As a result of the revisit,		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal so Tag numbers have been assigned Minnesota State Statutes for Assis Living License Providers. The assistag number appears in the far left entitled "ID Prefix Tag." The state number and the corresponding testate Statute out of compliance is the "Summary Statement of Deficicolumn. This column also includes findings which are in violation of the requirement after the statement, "Minnesota requirement is not met evidenced by." Following the surve findings is the Time Period for Conplease DISREGARD THE HEALTHE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TEDERAL DEFICIENCIES ONLY. WILL APPEAR ON EACH PAGE.  THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION STATUTES.  The letter in the left column is use tracking purposes and reflects the and level issued pursuant to 1440 subd. 1, 2, and 3.	oftware. to sted signed column Statute ct of the listed in encies" s the ne state This as eyors' rrection. DING OF THIS O DN FOR FATE d for scope
{0 470} SS=F		n 1 Minimum requirements	{0 470}		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.		F	₹
		30550	B. WING		1	8/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AGELES	S CARE INCORPORA	ATED	MN 56751			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
{0 470}	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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: No further action is required.		{0 470}			
{0 480} SS=F		·	{0 480}			
	(13) offer to provide following services to	e or make available at least the o residents:				

Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		20552			F	
		30550			11/1	8/2022
	PROVIDER OR SUPPLIER	702 7TH S	TREET SW	STATE, ZIP CODE		
AGELES	S CARE INCORPORA	ATED	MN 56751			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	.D BE	(X5) COMPLETE DATE
{0 480}	Continued From pa	ge 2	{0 480}			
	available seven day recommended dieta States Department guidelines, including fresh vegetables. T	critious meals daily with snacks ys per week, according to the ary allowances in the United of Agriculture (USDA) g seasonal fresh fruit and he following apply:  repared and served according bod Code, Minnesota Rules,				
	by: Based on observation review, the licenses prepared and server Food Code.  This practice resultiviolation that did not safety but had the president's health or widespread scope for represent a system.	ent is not met as evidenced on, interview and record e failed to ensure food was ed according to the Minnesota ed in a level two violation (at harm a resident's health or obtential to have harmed a safety) and was issued at a (when problems are pervasive emic failure that has affected to affect a large portion or all				
	The findings include	e:				
	and Beverage Esta	included document titled, Food blishment Inspection Report 3, 2022, for the specific ode deficiencies.				
{0 485} SS=C		(3) (i) (A) and (C) Minimum	{0 485}			

Minnesota Department of Health

STATE FORM 56899 J12I12 If continuation sheet 3 of 17

Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
					F	
		30550	B. WING		11/1	8/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AGELES	S CARE INCORPORA	ATED	STREET SW			
		ROSEAU,	MN 56751			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
{0 485}	Continued From pa	ge 3	{0 485}			
	(13) offer to provide following services t	e or make available at least the o residents:				
	available seven day recommended dieta States Department	tritious meals daily with snacks ys per week, according to the ary allowances in the United of Agriculture (USDA) g seasonal fresh fruit and he following apply:				
	advance, and made facility must encour menu planning. Me similar nutritional va	prepared at least one week in e available to all residents. The rage residents' involvement in al substitutions must be of alue if a resident refuses a Residents must be informed a changes;				
	(C) the facility cann and pay for meals i	ot require a resident to include n their contract;				
	This MN Requiremby: No further action is	ent is not met as evidenced required.				
{0 510} SS=F	144G.41 Subd. 3 Ir	nfection control program	{0 510}			
	maintain an infection complies with access nursing standards of (b) The facility's infection consistent with curricular centers for Prevention (CDC) of control in long-terms	g facilities must establish and on control program that pted health care, medical, and for infection control. ection control program must be tent guidelines from the program or infection prevention and care facilities and, as extended to the control in the cont				

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.		   F	,
		30550	B. WING			8/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AGELES	S CARE INCORPORA	ATED	STREET SW , MN 56751			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{0 510}	compliance with thi This MN Requirements by:	ties. t maintain written evidence of s subdivision. ent is not met as evidenced	{0 510}			
{0 550} SS=C	No further action is required.  144G.41 Subd. 7 Resident grievances; reporting maltreatment  All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center.  This MN Requirement is not met as evidenced by: No further action is required.		{0 550}			
{0 580} SS=F	The facility shall en appropriate to the s to the type of service management activity quality of care by poservices, complaint have occurred and in services, staffing	gage in quality management size of the facility and relevant ces provided. "Quality ty" means evaluating the eriodically reviewing resident as made, and other issues that determining whether changes, or other procedures need to be ensure safe and competent	{0 580}			

Minnesota Department of Health

STATE FORM 5899 J12I12 If continuation sheet 5 of 17

Minnesota Department of Health

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ,	E CONSTRUCTION	(X3) DATE COMP	
					   F	2
		30550	B. WING		11/1	8/2022
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
AGELES	S CARE INCORPORA	TED	TREET SW MN 56751			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
{0 580}	services to resident quality management wo years. Informat must be available to of the survey, invest This MN Requiremby:	ts. Documentation about nt activity must be available for ion about quality management to the commissioner at the time stigation, or renewal.	{0 580}			
{0 640} SS=F	No further action is required.  144G.42 Subd. 7 Posting information for		{0 640}			
{0 660} SS=F	(a) The facility must comprehensive tub program according tuberculosis infection	uberculosis prevention and st establish and maintain a erculosis infection control to the most current on control guidelines issued by Centers for Disease Control	{0 660}			

Minnesota Department of Health

STATE FORM 5699 J12I12 If continuation sheet 6 of 17

Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE	SURVEY LETED
			A. BUILDING:			
		30550	B. WING		F   11/1	₹ 8/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AGELES	S CARE INCORPORA	TFD	STREET SW			
040.15	CUIMMA DV CTA		MN 56751	DDOWDEDIC DI AN OF CODDECTION		0.(5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	D BE	(X5) COMPLETE DATE
{0 660}	Continued From pa	ge 6	{0 660}			
	Elimination, as publiand Mortality Week include a tuberculos covers all paid and contractors, studen volunteers. The cortechnical assistance the guidelines.  (b) The facility must compliance with this	ts, and regularly scheduled nmissioner shall provide e regarding implementation of at maintain written evidence of a subdivision.				
{0 680} SS=F	144G.42 Subd. 10 I emergency prepare	Disaster planning and diness	{0 680}			
	contains a plan for elements of shelter temporary relocation assignments in the emergency; (2) post an emerge (3) provide building all residents; (4) post emergency and (5) have a written promissing tenant residuals (b) The facility must disaster training to orientation and anni	mergency disaster plan that evacuation, addresses ing in place, identifies n sites, and details staff event of a disaster or an ancy disaster plan prominently; emergency exit diagrams to exit diagrams on each floor; olicy and procedure regarding				

Minnesota Department of Health

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMP	
		30550	B. WING		F 11/1	8/2022
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 11/1	O/ZUZZ
		702 7TH S	TREET SW	777112, 211 0002		
AGELES	S CARE INCORPORA	ROSEAU,	MN 56751			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
{0 680}	Continued From pa	ge 7	{0 680}			
	received emergence allowed to work onloworking on site. (c) The facility must requirements adopted	ent is not met as evidenced				
{0 800} SS=F	144G.45 Subd. 2 (a physical environme	a) (4) Fire protection and nt	{0 800}			
	walls, floors, ceiling systems, and equip good repair and op- health, safety, com-	cal environment, including I, all furnishings, grounds, Imment in a continuous state of Peration with regard to the Fort, and well-being of the Incance with a maintenance and				
	This MN Requirement by: No further action is	ent is not met as evidenced required.				
{0 810} SS=F	144G.45 Subd. 2 (b physical environme	o)-(f) Fire protection and nt	{0 810}			
	maintain fire safety plans shall include (1) location and n rooms; (2) employee acti a fire or similar eme (3) fire protection residents; and	iving facility shall develop and and evacuation plans. The but are not limited to: umber of resident sleeping ons to be taken in the event of ergency; procedures necessary for resident movement,				

Minnesota Department of Health

STATE FORM 56899 J12I12 If continuation sheet 8 of 17

Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE	
ANDILAN	OF CONTROLLONG	IDENTIFICATION NOMBER.	A. BUILDING:	<del></del>		
		30550	B. WING		R   11/18	8/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AGELES	S CARE INCORPORA	TFD	STREET SW MN 56751			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
{0 810}	Continued From pa	ge 8	{0 810}			
	evacuation, or relocemergency including or unusual resident evacuation.  (c) Employees of as receive training on a plans upon hiring at thereafter.  (d) Fire safety and or readily available at (e) Residents who at their own evacuation proper actions to tainclude movement, training shall be maleast once per year (f) Evacuation drills twice per year per sevacuation drill eve the residents is not activation is not required.	cation during a fire or similar g the identification of unique needs for movement or esisted living facilities shall the fire safety and evacuation at least twice per year evacuation plans shall be all times within the facility. The capable of assisting in a shall be trained on the ke in the event of a fire to evacuation, or relocation. The de available to residents at are required for employees whift with at least one required. Fire alarm system uired to initiate the evacuation ent is not met as evidenced				
{0 950} SS=F		signation of representative	{0 950}			
	assisted living continuat offer the resid a designated representation and must p	time of execution of an ract, an assisted living facility ent the opportunity to identify sentative in writing in the provide the following verbatiment separate from the contract:				
	"RIGHT TO DESIG FOR CERTAIN PUI	NATE A REPRESENTATIVE RPOSES.				

Minnesota Department of Health STATE FORM

Minnesota Department of Health

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	30550		B. WING		R <b>11/18/2022</b>	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
AGELES	S CARE INCORPORA	TFD	STREET SW , MN 56751			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{0 950}	You have the right to "Designated Representative can information and not some information readvocate on your be Representative does guardian, conserva ("attorney-in-fact"), attorney ("health cattorney ("health cattorney and contract must be name and contact in the research subdivision 1, paragright at any time to name and contact is representative.	o name anyone as your sentative." A Designated assist you, receive certain cices about you, including elated to your health care, and ehalf. A Designated as not take the place of your tor, power of attorney or health care power of are agent"), if applicable."  Just contain a page or space for act information of the entative and a box the resident sident declines to name a entative. Notwithstanding graph (f), the resident has the add, remove, or change the information of the designated ent is not met as evidenced	{0 950}			
{0 970} SS=C	The contract must a liability for the healt property of a reside include any provision should know to be a unenforceable under include any provision lesser standard of a required by law.	ivers of liability prohibited  not include a waiver of facility h and safety or personal ent. The contract must not on that the facility knows or deceptive, unlawful, or er state or federal law, nor on that requires or implies a care or responsibility than is ent is not met as evidenced	{0 970}			

6899

Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
30550			B. WING		F 11/1	R 8/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AGELES	S CARE INCORPORA	702 7TH S	STREET SW			
AGELLO		ROSEAU	, MN 56751			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
{0 970}	Continued From pa	ge 10	{0 970}			
	No further action is	required.				
{01470} SS=E	144G.63 Subd. 2 C	ontent of required orientation	{01470}			
	topics: (1) an overview of the control of the contr	must contain the following his chapter; and review of the facility's ures related to the provision ervices by the individual staff				
	person; (3) handling of eme emergency services (4) compliance with	rgencies and use of s; and reporting of the				
	maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC);					
	responsibilities related and protection of the	ng bill of rights and staff ted to ensuring the exercise ose rights; person-centered planning				
	and service delivery support services pro	y and how they apply to direct ovided by the staff person;				
	complaints, and wh including informatio Facility Complaints;					
	Ombudsman for Lo Ombudsman for Me	cacy services of the Office of ng-Term Care, Office of ental Health and abilities, Managed Care				
	Ombudsman at the Services, county-mother relevant advo	Department of Human anaged care advocates, or cacy services; and				
	services the employ facility's category of	ypes of assisted living yee will be providing and the ilicensure. e topics in paragraph (a),				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	-	
AGELES	S CARE INCORPORA	TFD	MN 56751			
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{01470}	orientation may also services to resident training on hearing subdivision must be based, may include include training on otopics:  (1) an explanation of and how it manifest the challenges it pode (2) health impacts rage-related hearing incidence of demensiolation, and depresionation, and depresionation about that may enhance of involvement, including assistive listening of and tactile alerting of access in real time,	o contain training on providing is with hearing loss. Any loss provided under this high quality and research online training, and must one or more of the following of age-related hearing loss is itself, its prevalence, and ses to communication; elated to untreated loss, such as increased itia, falls, hospitalizations, ession; or cut strategies and technology communication and ing communication strategies, evices, hearing aids, visual devices, communication and closed captions.	{01470}			
	(a) All assisted livin following training re (1) supervisors of d least eight hours of specified under par hours of the employ have at least two hor related to dementia employment therea (2) direct-care emp	irect-care staff must have at initial training on topics agraph (b) within 120 working ment start date, and must ours of training on topics care for each 12 months of	{01530}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		R	
		30550	B. WING			8/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AGELES	S CARE INCORPORA	TED	STREET SW , MN 56751			
(VA) ID	STIMMA DV STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTI		(VE)
(X4) ID PREFIX TAG	(= 1 0 )   = = 10   = 10   (1 0 )   0 = = = = = = = = = = = = = = = = = =		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{01530}	Continued From page 12 {01530}					
	hours of the employ initial training is corprovide direct care employee on site weight hours of trainidementia care and and assist if issues requirements under meeting the require available for consuluntil the training recupirect-care employ hours of training on each 12 months of This MN Requirements:  No further action is	·				
{01650} SS=F	and revisions to  (f) The service plant (1) a description of the fees for service service, according to assessment and re (2) the identification who will provide the (3) the schedule an assessments of the (4) the schedule an providing services; (5) a contingency p (i) the action to be to	the services to be provided, s, and the frequency of each to the resident's current sident preferences; n of staff or categories of staff e services; d methods of monitoring e resident; d methods of monitoring staff and lan that includes: aken if the scheduled service	{01650}			

Minnesota Department of Health

STATE FORM 56899 J12I12 If continuation sheet 13 of 17

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING: (X3)			(X3) DATE SURVEY COMPLETED	
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		30550	B. WING			8/2022
NAME OF F	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
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040.15	CLIMMA DV CTA		MN 56751	DROVIDEDIS DI AN OF CORDECTI	ON	()(5)
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{01650}	Continued From pa	ge 13	{01650}			
	the resident wishes emergency or if the change in the residentification of and authority to sign for and (iv) the circumstance medical services are consistent with change chapters.  This MN Requirements:					
{01790} SS=F	No further action is required.  790} 144G.71 Subd. 10 Medication management for		{01790}			

iviinneso	<u>ita Department of He</u>	ealth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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					1 11/1	0/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AGELESS CARE INCORPORATED		MN 56751				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
{01790}	Continued From pa	ge 14 d determined the unlicensed	{01790}			
	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 medication system;					
	labeled;	er or containers must be				
	be provided;	ion about the medications to sed staff must document in				
	the resident's recor	d that medications have been documenting the date the				
	medications were p	provided and who received the erson who provided the				
	medications that we	resident, the number of ere provided to the resident,				
		information; ed nurse shall be notified that een provided and whether the				
	registered nurse ne	eds to be contacted before given to the resident or the				
	designated represe (vi) a review by the	ntative; registered nurse of the				
	completed accurate	ask to verify that this task was ely by the unlicensed				
		nsed personnel must sident's record any unused				
	medications that are	e returned to the facility, of each medication and the				
	uoses oi eacii retur	neu medication.				

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
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		30550	B. WING			8/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
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{01790}	Continued From page 15		{01790}			
	This MN Requirements by: No further action is	ent is not met as evidenced required.				
{01890} SS=F			{01890}			
	immediate or later a the original containe by the pharmacy be label with legible inf	prior to being set up for administration, must be kept in er in which it was dispensed earing the original prescription formation including the d-use date of a time-dated				
	This MN Requirements by: No further action is	ent is not met as evidenced required.				
{02310} SS=D	310} 144G.91 Subd. 4 (a) Appropriate care and services		{02310}			
	living services that resident's needs an	e the right to care and assisted are appropriate based on the ad according to an up-to-date t to accepted health care				
	This MN Requirements by: No further action is	ent is not met as evidenced required.				
{03090} SS=C	Subd. 8.Notice to via sign at each facility visitors that states:	Notice to Visitors isitors. (a) A facility must post ty entrance accessible to "Electronic monitoring security cameras and audio	{03090}			
	Subd. 8.Notice to via sign at each facility visitors that states: devices, including s	isitors. (a) A facility must post ty entrance accessible to "Electronic monitoring	{03090}			

Minnesota Department of Health

STATE FORM 5699 J12I12 If continuation sheet 16 of 17

Minnesota Department of Health

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
30550		B. WING		R 11/18	3/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AGELES	S CARE INCORPORA	\	STREET SW , MN 56751			
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{03090}	activities."  (b) The facility is re maintaining the sign subdivision.	sponsible for installing and nage required in this ent is not met as evidenced	{03090}	DEFICIENCY)		



Protecting, Maintaining and Improving the Health of All Minnesotans

**Electronically Delivered** 

September 13, 2022

Administrator
Ageless Care Incorporated
702 7th Street Southwest
Roseau, MN 56751

RE: Project Number(s) SL30550015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on August 23, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

#### **IMPOSITION OF FINES**

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

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

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of \$1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2,

Ageless Care Incorporated September 13, 2022 Page 2

9, 17. The Department of Health also may impose a fine of \$5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program = \$500

The total amount you are assessed is \$500. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

# **DOCUMENTATION OF ACTION TO COMPLY**

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

The correction order documentation should include the following:

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

#### **CORRECTION ORDER RECONSIDERATION PROCESS**

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

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

Please address your cover letter for general reconsideration requests to:

Reconsideration Unit

Health Regulation Division

Free from Maltreatment reconsideration requests should be addressed to:

Reconsideration Unit

Health Regulation Division

Ageless Care Incorporated September 13, 2022 Page 3

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

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

#### **REQUESTING A HEARING**

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

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

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Jessie Chenze, RN, BSN

Interim HFE Supervisor 1 | State Evaluations Team

Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 3879

St. Paul, MN 55101-3879

Office: 218-332-5175 | Mobile: 651-508-2791 | Fax: 218-332-5196

**PMB** 

Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		30550	B. WING		08/23/2022	
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
AGELES	S CARE INCORPORA	TFD	TREET SW MN 56751			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETE	
0 000	Initial Comments		0 000			
	In accordance with 144G.08 to 144G.9 issued pursuant to a Determination of what requires compliance provided at the State When Minnesota S failure to comply with considered lack of a INITIAL COMMENT SL30550015  On, August 22, 202 the Minnesota Department of the Minnesota Department	PROVIDER LICENSING DER(S)  Minnesota Statutes, section 5, these correction orders are a survey.  The survey are corrected to the with all requirements are number indicated below. It is the survey are the survey are the survey.  The survey are the		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal so Tag numbers have been assigned Minnesota State Statutes for Assis Living License Providers. The assitag number appears in the far left entitled "ID Prefix Tag." The state number and the corresponding testate Statute out of compliance is the "Summary Statement of Deficicolumn. This column also includes findings which are in violation of the requirement after the statement, "Minnesota requirement is not met evidenced by." Following the surve findings is the Time Period for Corplease DISREGARD THE HEALTHE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TEDERAL DEFICIENCIES ONLY. WILL APPEAR ON EACH PAGE.  THERE IS NO REQUIREMENT TOUR STATUTES.  The letter in the left column is use tracking purposes and reflects the and level issued pursuant to 144G subd. 1, 2, and 3.	oftware. to sted signed column Statute ct of the listed in lencies" s the lie state This as leyors' rrection.  DING OF  THIS  O  ON FOR FATE  d for scope	
0 470 SS=F		n 1 Minimum requirements	0 470			
	(11) develop and im	plement a staffing plan for				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  O 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	STATEMENT OF DE AND PLAN OF COR	EFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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AGELESS CARE INCORPORATED  ROSEAU, MN 56751  (A) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY) MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  O 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	NAME OF PROVIDE	ER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CX4) ID   PREFIX   CEACH DEFICIENCY MUST BE PRECEDED BY FULL   PREFIX   TAG   REGULATORY OR LSC IDENTIFYING INFORMATION)   TAG   PROVIDER'S PLAN OF CORRECTION COMPLETE DATE	AGELESS CAR	RE INCORPORA	NTFD				
DEFICIENCY)  0 470 Continued From page 1 0 470 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	PRÉFIX (E	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	(EACH CORRECTIVE ACTION SHOUL	.D BE	COMPLETE
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	TAG RE	REGULATORY OR LSC IDENTIFYING INFORMATION)				PRIATE	DATE
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 develop and implement a staffing plan to determine staffing levels to meet the needs of all residents; and failed to ensure the staffing schedule was posted as required. 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	deterr (i) incl least t staffin (ii) en: the so unsch by the on a 2 (iii) en and e and to situati (12) e availa who a reque safety (i) awa (ii) loo buildir facility amou (iii) ca (iv) ca appro (v) ca This N by: Based review implet levels failed as rec reside	rmining its staffoldes an evaluation and levels in the asures sufficient cheduled and heduled needs are residents' as 24-hour per dansures that the effectively to into emergency, tions affecting ensure that on able 24 hours are responsible ests of residenty needs. Such wake; cated in the saing, or on a cody in order to resunt of time; apable of compapable of provopriate assistant apable of follows.  MN Requirement of the ensure the result of the	fing level that: uation, to be conducted at of the appropriateness of e facility; Int staffing at all times to meet reasonably foreseeable s of each resident as required sessments and service plans ay basis; and e facility can respond promptly dividual resident emergencies life safety, and disaster staff or residents in the facility; e or more persons are per day, seven days per week, e for responding to the ts for assistance with health or persons must be:  Imme building, in an attached ntiguous campus with the espond within a reasonable  municating with residents; iding or summoning the nce; and wing directions;  ent is not met as evidenced fon, interview and record of failed to develop and g plan to determine staffing needs of all residents; and staffing schedule was posted and the potential to affect all visitors.  ed in a level two violation (a	0 470			

Minnesota Department of Health

STATE FORM 5899 J12I11 If continuation sheet 2 of 45

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
30550		50	B. WING		08/	23/2022
NAME OF PROVIDER OR SUPPL	≣R	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AGELESS CARE INCORPO	RATED		STREET SW MN 56751			
PREFIX (EACH DEFICIE	NCY MUST BE F	DEFICIENCIES RECEDED BY FULL (ING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
resident's health widespread sco or represent a sor has the poter of the residents.  The findings income the license her license. The fact 20 residents and residents.  During the entrate 2022, at 11:43 at assisted living of identified as the surveyor asked plan. RN/LALD-smaller facility In RN/LALD-smaller facility In RN/LALD-smaller facility In RN/LALD was at the day shift where the day shift where the day shift where the evening should be remarked by the new one ULP on from 8:00 the evening should be remarked by the new one ULP on from 8:00 the evening should be remarked by the new one ULP on from 8:00 the evening should be remarked by the new one ULP on from 8:00 the evening should be remarked by the new one ULP on from 8:00 the evening should be remarked by the new one ULP on from 8:00 the evening should be remarked by the new of the remarked by the new of the remarked by the new of the remarked by the remarke	e potential to or safety) and see (when provided it is a safety) and see (when provided it is a safety) and see (when provided it is a safety) and see (when	sed for a capacity of nt census of 19  ace on August 22, ed nurse/licensed ALD)-A was a supervisor. The the facility's staffing cause we are a re needed one." cility did not have a re needed one." cility did none usual staffing as follows:  10 hours a week onday-Thursday with one ULP from 11:00 ay the facility was a shift.  20 p.m., the surveyor LD-A. The surveyor	0 470			

Minnesota Department of Health

STATE FORM 56899 J12I11 If continuation sheet 3 of 45

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		30550	B. WING		08/	23/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	ODRESS, CITY, S	STATE, ZIP CODE		
AGELES	S CARE INCORPORA	TFD	STREET SW , MN 56751			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
0 470	Continued From pa	ge 3	0 470			
	desk in the nursing the staffing schedul	the staff schedule was on a office. RN/LALD-A confirmed le for the day was not posted and visitors to be able to				
	No further informati	on was provided.				
	TIME PERIOD FOR (21) days	R CORRECTION: Twenty-One				
0 480 SS=F	144G.41 Subd 1 (1 requirements	3) (i) (B) Minimum	0 480			
	(13) offer to provide following services to	or make available at least the presidents:	,			
	available seven day recommended dieta States Department	ritious meals daily with snacks  /s per week, according to the ary allowances in the United of Agriculture (USDA) g seasonal fresh fruit and he following apply:				
		repared and served according good Code, Minnesota Rules,				
	by: Based on observati review, the licensee	ent is not met as evidenced on, interview and record e failed to ensure food was ed according to the Minnesota				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
30550		B. WING		08/23/2022		
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
AGELES	S CARE INCORPORA	TFD	STREET SW MN 56751			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 480	Continued From page 4		0 480			
	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	e:				
	Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated August 23, 2022, for the specific Minnesota Food Code deficiencies.					
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days					
0 485 SS=C	85 144G.41 Subd 1. (13) (i) (A) and (C) Minimum Requirements		0 485			
	(13) offer to provide following services to	e or make available at least the presidents:				
	available seven day recommended dieta States Department	ritious meals daily with snacks os per week, according to the ary allowances in the United of Agriculture (USDA) g seasonal fresh fruit and he following apply:				
	(A) menus must be prepared at least one week in advance, and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes;					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
30550		B. WING		08/	08/23/2022	
	PROVIDER OR SUPPLIER S CARE INCORPORA	702 7TH S	DRESS, CITY, S STREET SW MN 56751	TATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
0 485	Continued From pa	ge 5	0 485			
	(C) the facility cann and pay for meals i	ot require a resident to include n their contract;				
	This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to post a menu a week in advance that was made available to all residents and failed to offer meal substitutions of similar nutritional value. 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 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).					
	2022, at 11:45 a.m. assisted living direct meals for the reside café. RN/LALD-Assi	e: e conference on August 22, , registered nurse/licensed ctor (RN/LALD)-A stated all ents were catered by a nearby tated they are in the process g vendors as the current				
	caterer does not su substitutes with each During the facility to 22, 2022, at 12:28 plarge white board of area with a handwr Tuesday, and Wedi	pply alterative meals or				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	30550		B. WING		08/23/2022	
NAME OF I	PROVIDER OR SUPPLIER		1	STATE, ZIP CODE	00/2	3/2022
		702 7TH	STREET SW	JIAIE, ZII OODE		
AGELES	S CARE INCORPORA	ROSEAU	, MN 56751			
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	N SHOULD BE COMPLETE E APPROPRIATE DATE	
0 485	Continued From page 6  Friday, Saturday, and Sunday sections were blank. RN/LALD-A stated they are unable to provide a weekly menu to the residents because the catering vendor only delivered meals twice a week (on Mondays and Thursdays). On Monday when the meals are delivered, they will know what is going to be served for Monday, Tuesday, and Wednesday; on Thursday when the meals are delivered, they will know what is going to be serviced for Thursday, Friday, Saturday, and Sunday. RN/LALD-A stated they are not made aware of what is going to be provided to residents until these deliver dates.  No further information was provided.  TIME PERIOD FOR CORRECTION: Twenty-One (21) days		0 485			
0 510 SS=F			0 510			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		30550	B. WING		08/2	23/2022
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
AGELES	S CARE INCORPORA	TFD .	TREET SW MN 56751			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
0 510	maintain an effective comply with accepted nursing standards for recommendations of the wearing appropriate equipment (PPE). The standard of the resident's health or widespread scope (or represent a system or has the potential of the residents).  The findings included the findings included the residents.  The Minnesota Deguidance titled, CO Equipment (PPE) and April 7, 2022, indicated working with reside or confirmed SARS face mask and eye with substantial and levels.  On August 22, 2022 observed unlicense a blood glucose ches scheduled insulin a surveyor observed surgical grade mas no appropriate eye.	re infection control program to ed health care, medical, and or infection control and current for COVID-19 regarding e personal protective. This had the potential to affect ff, and visitors.  red in a level two violation (a tharm a resident's health or obtential to have harmed a safety) and was issued at a (when problems are pervasive emic failure that has affected to affect a large portion or all extended to affect a large portion or all extended to affect a large portion or all extended to a tended the extended the extended to a tended the extended the extended t	0 510			
		dminister R4's scheduled on. The surveyor observed				

Minnesota Department of Health

STATE FORM 5699 J12I11 If continuation sheet 8 of 45

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
30550		B. WING		08/23/2022		
NAME OF	PROVIDER OR SUPPLIER		DRESS CITY S	STATE, ZIP CODE	1 00/2	.0,2022
		702 7TH 9	STREET SW	37.11.2, 21. 3332		
AGELES	S CARE INCORPORA	ROSEAU	, MN 56751			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 510	Continued From pa	ige 8	0 510			
	ULP-C to be wearing a surgical grade mask and prescription glasses, but no appropriate eye protection.					
	observed ULP-C to site care and applie stockings. The surv wearing a surgical	2, at 9:09 a.m., the surveyor provide suprapubic catheter ed R5's compression veyor observed ULP-C to be mask and prescription propriate eye protection.				
	On August 23, 2022, at 12:14 p.m., registered nurse/licensed assisted living director (RN/LALD)-A stated the facility tries to follow the Minnesota Department of Health (MDH) guidelines. RN/LALD-A stated if a resident has symptoms of COVID-19 or a confirmed case of COVID-19 then the staff are to wear a mask, eye protection, gloves, and a gown when in contact with the resident. RN/LALD-A was not familiar with the PPE Grid referenced above. RN/LALD-A reviewed with the surveyor the facility's county transmission level on the computer. RN/LALD-A stated the current county transmission level was high, so according to the PPE Grid staff should be wearing eye protection when working with residents with or without suspected or confirmed COVID-19.					
	Sourcing, Optimizir dated June 2020, r the licensee would visitors, and vendo	sonal Protective Equipment ng and Alternatives policy, noted in the policy statement provide healthcare workers, rs with appropriate PPE and federal guidelines.				
	No further informat	ion was provided.				
	TIME PERIOD FOR CORRECTION: Two (2)					

Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
30550		B. WING		08/23/2022		
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
AGELESS	S CARE INCORPORA	(TFD	TREET SW MN 56751			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
	Maltreatment  All facilities must poinformation about the procedure, and the e-mail contact information for the south of the notice must also information for the south of the Office of Ombuds of the Minnesota Active Minnesota Active This MN Requirements of the Minnesota Active This MN Requirements of the Grievance processor of the Minnesota Adult Ab (MAARC) as required affect all current resolution that has not a minimal impact of affect health or safe widespread scope (or represent a system or has potential to a the residents).  The findings include On August 22, 2022 toured the facility were and the residents of the south of th	state and applicable regional can for Long-Term Care and dsman for Mental Health and abilities, and must have orting suspected maltreatment dult Abuse Reporting Center.  The sent is not met as evidenced on and interview, the licensee quired information related to edure, as well as information cted maltreatment to the use Reporting Center ed. This had the potential to sidents, staff and visitors.  The din a level one violation (a potential to cause more than in the resident and does not ety), and was issued at a (when problems are pervasive emic failure that has affected affect a large portion or all of	0 550	DEFICIENCY)		

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Minnesota Department of Health STATE FORM

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		30550	B. WING		08/23/2022	
	PROVIDER OR SUPPLIER	702 7TH S	DRESS, CITY, S STREET SW MN 56751	STATE, ZIP CODE		
(X4) ID PREFIX TAG	EIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
0 550	main entrance and/required posting for include the name, to contact information responsible for han contact information regional Office of Cand Developmenta for reporting susperior of Cand Developmental for the conformation for the conformation for the conformation for MA/required.	/or common areas lacked the r the grievance procedure to delephone number, and e-mail of or the individuals who are adding resident grievances; of or the state and applicable ombudsman for Mental Health I Disabilities; and information cted maltreatment to MAARC.  2, at 12:24 p.m., RN/LALD-A dee procedure, contact state and applicable regional man for Mental Health and abilities; and contact ARC were not posted as	0 550			
0 580 SS=F	appropriate to the set to the type of service management activity quality of care by preservices, complainty have occurred and in services, staffing be made in order to services to residenty quality management two years. Informat must be available to	gage in quality management size of the facility and relevant ces provided. "Quality ty" means evaluating the eriodically reviewing resident as made, and other issues that determining whether changes is, or other procedures need to be ensure safe and competent activity must be available for tion about quality management to the commissioner at the time estigation, or renewal.	0 580			

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PRINTED: 09/13/2022 FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		30550	B. WING		08/	23/2022
	PROVIDER OR SUPPLIER	702 7TH S	DRESS, CITY, S STREET SW , MN 56751	TATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
0 580	by:	ent is not met as evidenced	0 580			
	licensee failed to er documentation of q appropriate to the s services provided b	and record review, the ngage in and maintain uality management activity ize and relevant to the type of y the assisted living. This had ct all 19 residents receiving ces.				
	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	e: conference on August 22,				
	2022, at 12:10 p.m. registered nurse/lic (RN/LALD)-A for the licensee's quality m RN/LALD-A stated handwashing compand then shares thi meetings. RN/LALD anything formalized	the surveyor asked ensed assisted living director documentation of the anagement activities. She collects data on liance and incidents like falls information at the staff D-A stated she did not have to provide the surveyor with quality management activities.				
	August 1, 2022, not a quality improvement of the facility and ap services provided. I	lity Management policy dated red the facility would establish ent program based on the size opropriate to the type of Documentation of Quality am would be maintained for at				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		30550	B. WING		08/2	3/2022
NAME OF F	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
AGELES	S CARE INCORPORA	ATED	STREET SW MN 56751			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 580	Continued From pa	ge 12	0 580			
		would be provided to the e time of survey, investigation ested.				
	No further informati	ion was provided.				
	TIME PERIOD FOR (21) days	R CORRECTION: Twenty-One				
0 640 SS=F	144G.42 Subd. 7 P reporting suspected	osting information for d c	0 640			
	through access to the reporting suspected suspected vulnerable (1) posting the 911 common areas and the assisted living for the Minnesota Action to report suspected adult under section (3) providing reason	tion and the reporting number dult Abuse Reporting Center maltreatment of a vulnerable				
	by: Based on observatifailed to post requirarea to include post number and failed to the Minnesota A (MAARC) to report	ent is not met as evidenced on and interview, the licensee ed content in the common ting the 911 emergency to post the reporting number dult Abuse Reporting Center suspected maltreatment of a der section 626.557				
	violation that did no	ed in a level two violation (a t harm a resident's health or potential to have harmed a				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		30550	B. WING		08/	23/2022	
	PROVIDER OR SUPPLIER	702 7TH S	DRESS, CITY, S STREET SW MN 56751	STATE, ZIP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE	
0 640	resident's health or widespread scope or represent a syste or has the potential of the residents).  The findings include On August 22, 2022 toured the facility wassisted living direct main entrance and/required posting for and information and MAARC to report sivulnerable adult uncontact information as required.  No further information	safety) and was issued at a (when problems are pervasive emic failure that has affected to affect a large portion or all e:  2, at 12:20 p.m., the surveyor ith registered nurse/licensed etor (RN/LALD)-A, noting the for common areas lacked the the 911 emergency number do the reporting number for uspected maltreatment of a der section 626.557.  2, at 12:24 p.m., RN/LALD-A rgency number and the for MAARC were not posted	0 640				
0 660 SS=F	144G.42 Subd. 9 T control  (a) The facility must comprehensive tub program according tuberculosis infection the United States C and Prevention (CE Elimination, as pub	uberculosis prevention and st establish and maintain a erculosis infection control to the most current on control guidelines issued by centers for Disease Control DC), Division of Tuberculosis lished in the CDC's Morbidity ly Report. The program must	0 660				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	30550	B. WING	B. WING		3/2022
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
AGELESS CARE INCORPORAT	(FD)	STREET SW MN 56751			
PREFIX (EACH DEFICIENCY	(4) ID SUMMARY STATEMENT OF DEFICIENCIES REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
volunteers. The comtechnical assistance the guidelines.  (b) The facility must compliance with this  This MN Requireme by: Based on interview a licensee failed to ensand maintained a tult program based on this sued by the Center Prevention (CDC) with facility risk assessmental to the president's health or swidespread scope (vor represent a system or has the potential to fithe residents).  The findings include  TB RISK ASSESSM On August 22, 2022, entrance conference licensee's facility TB  On August 22, 2022, nurse/licensed assis (RN/LALD)-A provide	unpaid employees, s, and regularly scheduled missioner shall provide regarding implementation of t maintain written evidence of subdivision.  Int is not met as evidenced and record review, the sure the provider established berculosis (TB) prevention he most current guidelines rs for Disease Control and hich included completion of a ent and implementation of a plan.  Ind in a level two violation (a harm a resident's health or otential to have harmed a safety) and was issued at a when problems are pervasive mic failure that has affected to affect a large portion or all in the surveyor asked for the entire trisk assessment.  IENT  The state of the surveyor asked for the entire trisk assessment.  The state of the surveyor asked for the entire trisk assessment.	0 660	DELIGITION )		

	MENT OF DEFICIENCIES LAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		30550	B. WING		08/2	3/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AGELES	S CARE INCORPORA	TED	STREET SW , MN 56751			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 660	the Minnesota Department of Health (MDH) TB risk assessment worksheet, however, had not		0 660			
	TB INFECTION CO The licensee lacked plan to include: - identification of su the TB infection col - procedures for had or active TB disease On August 23, 2023 stated she had not control plan for the	d a written TB infection control apervisory responsibilities for introl program, and indling persons with suspected the 2, at 3:07 p.m., RN/LALD-a developed a TB infection facility.				
	noted the licensee recommended pred prevention as ident The precautions in TB Prevention Plar other year and upd	cautions related to TB ified by the CDC and MDH. cluded a risk assessment. The would be reviewed every ated, if needed.				
0 680 SS=F	144G.42 Subd. 10 emergency prepare	Disaster planning and edness	0 680			
	requirements: (1) have a written econtains a plan for	t meet the following mergency disaster plan that evacuation, addresses ing in place, identifies				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	30550	B. WING		08/23/2022	
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AGELESS CARE INCORPORA	TED	MN 56751			
PREFIX (EACH DEFICIENCY	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
assignments in the emergency; (2) post an emerger (3) provide building all residents; (4) post emergency and (5) have a written post disaster training to a orientation and annumake emergency at available to all residence demergency allowed to work only working on site. (c) The facility must requirements adopt  This MN Requirements adopt  This MN Requirements adopt  This practice resulter review, the licenseed emergency preparer required content. The all residents, staff, at this practice resulter violation that did not safety but had the president's health or widespread scope (or represent a systematical systematics).	n sites, and details staff event of a disaster or an any disaster plan prominently; emergency exit diagrams to a exit diagrams on each floor; olicy and procedure regarding dents. It provide emergency and all staff during the initial staff ually thereafter and must and disaster training annually lents. Staff who have not any and disaster training are also at meet any additional and in rule.  The ent is not met as evidenced and in rule.  The ent is not met as evidenced and the potential to affect and visitors of the facility.  The ent is a level two violation (and the harm a resident's health or potential to have harmed a safety), and was issued at a fawhen problems are pervasive emic failure that has affected to affect a large portion or all	0 680			

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		30550	B. WING		08/23/2022	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
AGELES	S CARE INCORPORA	TFD .	STREET SW MN 56751			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
0 680	Continued From pa	ge 17	0 680			
	2022, at 12:15 p.m. licensee's emergen	e conference on August 22, , the surveyor asked for the cy preparedness plan (EPP), I to and later reviewed by the				
	was conducted with assisted living direct no observed signates	2, at 12:22 p.m., a facility tour in registered nurse/licensed etor (RN/LALD)-A. There was ge posted or information see's EPP in the common				
	The licensee's plan provided to the surveyor included an undated hazard vulnerability assessment (HVA) which indicated 17 hazards (such as train derailment, chemical spill, tornado, flood, fire, power outage, pandemic etc.) and scored each event based on probability, mitigation, and greatest threat. The plan included an Emergency Plan which provided basic direction for the staff to follow in the case of a fire, thunderstorm watch, tornado warning/watch, evacuation, blizzard, and power outage.					
	- policies and proce man-made disaster - a description of th meeting the health/ staff and residents; - process for EP co EP officials/organiz - arrangements/cor services; - a description of th licensee; - development of po - procedure for	e facilities approach to safety/security needs of the operation with state and local				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		30550	B. WING		08/2	3/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AGELES	S CARE INCORPORA	ATED	STREET SW MN 56751			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
0 680	during an emergen medical supplie and waste disposa detection, extir - evacuation pl responsibilities dur transporting se evacuated; - shelter in place needs of the resident - a medical recepreserve resident in availability; - development facilities and providented; and - the facilities retreatment at alternative; - a communication - arrangement - names and corresident physicians - contact inform local EP staff, omb certification agencies - primary and a communicating with regional and loagencies; - a method of semedical documents	cy to include (food, water, es, pharmacy supplies, sewer I, emergency lighting, fire aguishing and alarm systems); an which included staffing an evacuation and ervices for residents being the ents; ord documentation system to information, security, and of arrangements with other lers to receive residents if the ole in providing care and eative sites under a 1135 plan that included: with other facilities; ontact information for staff, es, other facilities, volunteers; mation for federal, state, tribal, udsman, state licensing and es; elternative means for in facility staff, federal, state, cal emergency management sharing information and eation for residents;	0 680			
	the facility's needs, assistance to it occupancy; and - a method of s EPP with residents					
l	On August 23, 202	2, at 12:05 p.m., RN/LALD-A				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		30550	B. WING		08/23/2022	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	-	
AGELES	S CARE INCORPORA	TFD	TREET SW MN 56751			
(X4) ID PREFIX TAG	EIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 680	section of the Center Services [CMS] state includes the emerging guidelines). RN/LA the facility's EPP was not fully developed. The licensee's Emerganuary 2018, note in place to be used needed in times of the No further information.	iliar with Appendix Z (a ers for Medicare and Medicaid ted operations manual which ency preparedness LD-A stated she was aware as a work in progress and was and implemented.  ergency Plan policy dated d emergency plans would be by staff and participants if emergency.	0 680			
0 800 SS=F	physical environme  (4) keep the physic walls, floors, ceiling systems, and equip good repair and open health, safety, commercial repair program.  This MN Requirements by: Based on observatificated to provide the continuous state of with regard to the hither esidents. This affect all residents a	cal environment, including, all furnishings, grounds, ment in a continuous state of eration with regard to the fort, and well-being of the ance with a maintenance and ent is not met as evidenced on and interview, the licensee a physical environment in a good repair and operation ealth, safety, and well-being of had the potential to directly	0 800			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		COMPLETED		
		20550	B. WING		00/0	2/2222
		30550	B. WIIIO		08/2	3/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AGELES	S CARE INCORPORA	TFD	MN 56751			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
0 800	violation that did no safety but had the president's health or widespread scope (or represent a syste or has the potential of the residents). The On August 23, 2022 p.m., survey staff to registered nurse/lice (RN/LALD)-A. Durir observed the follow 1. Three marked en provided with signathese doors were marked these doors were marked these doors were marked these signs need RN/LALD-A confirm that these signs need RN/LALD-A remove facility tour.  2. The bathroom lig resident room 6 was 3. The bathroom expresident room 18 was 1. The RN/LALD-A confirm that these was 1. The RN/LALD-A confirm that these was 1. The pathroom that these was 1. The pathroom that these was 1. The RN/LALD-A confirm that these was 1. The pathroom that these was 1. The RN/LALD-A confirm that the second that the	tharm a resident's health or potential to have harmed a safety) and was issued at a when problems are pervasive emic failure that has affected to affect a large portion or all he findings include:  2, between 1:00 p.m. and 1:55 pured the facility with the ensed assisted living directoring the facility tour, survey staffing:  Intergency exit doors were ge stating "Stop". Two of parked "not an exit" and the seed "do not use". The led during the tour interviewed to be removed. The end these signs during the ht fixture on the ceiling in as not provided with a cover. That the cover in the ceiling in as missing a cover.  Infirmed during the tour fixtures required covers.	0 800			
0 810 SS=F	days 144G.45 Subd. 2 (b physical environme	o)-(f) Fire protection and nt	0 810			
	(b) Each assisted l	iving facility shall develop and				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			X3) DATE SURVEY COMPLETED	
		30550	B. WING		08/2	3/2022	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 00/2	3/2022	
		702 7TH S	STREET SW	STATE, ZIF GODE			
AGELES	S CARE INCORPORA	ROSEAU,	MN 56751				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
	plans shall include (1) location and noroms; (2) employee active a fire or similar emetals; and (3) fire protection residents; and (4) procedures for evacuation, or relocated emergency including or unusual resident evacuation. (c) Employees of as receive training on plans upon hiring a thereafter. (d) Fire safety and readily available at	and evacuation plans. The but are not limited to: umber of resident sleeping ons to be taken in the event of ergency; procedures necessary for resident movement, cation during a fire or similar g the identification of unique needs for movement or essisted living facilities shall the fire safety and evacuation at least twice per year evacuation plans shall be all times within the facility.					
	their own evacuation proper actions to take include movement, training shall be made least once per year (f) Evacuation drills twice per year per sevacuation drill eventhe residents is not activation is not required.  This MN Requirements by:  Based on observation interview, the licens required plans, empressed in the state of t	are required for employees shift with at least one ry other month. Evacuation of required. Fire alarm system uired to initiate the evacuation ent is not met as evidenced on, document review, and see failed to provide the ployee training, and drills for cuation. This had the potential					

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		30550	B. WING		08/2	3/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AGELES	SS CARE INCORPORA	ATED	MN 56751			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 810	This practice result violation that did no safety but had the president's health or widespread scope or represent a syst or has the potential of the residents). To August 23, 202 p.m., survey staff to registered nurse/lic (RN/LALD)-A. Duri observed that the losleeping rooms we evacuation maps pinterview with the Four, they confirme rooms were not lab. On August 23, 2022, the RN/LALD-A production was read august 23, 2022, b p.m.  1. The fire plan dat the identification of needs for moveme 2. The licensee fail employee training for stated during an interpolation was continued to the service per year after 3. The licensee fail drills twice per year were provided for roompleted either displacements.	red in a level two violation (a of harm a resident's health or potential to have harmed a safety) and was issued at a (when problems are pervasive emic failure that has affected to affect a large portion or all he findings include:  2, between 1:00 p.m. and 1:55 pured the facility with the sensed assisted living directoring the facility tour, survey staff ocation and number of resident re not identified on the osted in the facility. In an RN/LALD-A during the facility detent the resident sleeping seled.  2, at approximately 1:55 p.m., ovided documents for review. Eviewed by survey staff on etween 1:55 p.m. and 2:10 ed 08-01-2021 failed to include funique or unusual resident int or evacuation. ed to provide the required frequency. The RN/LALD-A terview, at approximately 2:00 etraining for fire safety and inpleted during orientation and id not require training at least	0 810			

	OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		30550	B. WING		08/2	3/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
AGELES	S CARE INCORPORA	TFD .	TREET SW MN 56751			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
0 810	Continued From pa	ge 23	0 810			
		imately 2:00 p.m., that d not been completed during				
	the RN/LALD-A con that the licensee fai content within the fi and that the training not met. The RN/LA	2, at approximately 2:10 p.m., afirmed during an interview led to provide the required re safety and evacuation plans g frequency for employees was ALD-A stated that the facility ing evacuation drills during the				
	No further informati	on was provided.				
	TIME PERIOD FOF (21) days	R CORRECTION: Twenty-one				
0 950 SS=F	144.50 Subd. 3 Des	signation of representative	0 950			
35-1	assisted living contr must offer the resid a designated repres contract and must p	time of execution of an ract, an assisted living facility ent the opportunity to identify sentative in writing in the provide the following verbatiment separate from the contract:				
	"RIGHT TO DESIG FOR CERTAIN PUI	NATE A REPRESENTATIVE RPOSES.				
	"Designated Representative can information and not some information readvocate on your be Representative doe guardian, conservation and the service of the s	o name anyone as your sentative." A Designated assist you, receive certain ices about you, including elated to your health care, and ehalf. A Designated is not take the place of your tor, power of attorney or health care power of				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		30550	B. WING		08/2	3/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
AGELES	S CARE INCORPORA	ATED	TREET SW MN 56751			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
0 950	(b) The contract muthe name and contadesignated represe must initial if the redesignated represe subdivision 1, paragright at any time to name and contact i representative.  This MN Requirements by: Based on interview licensee failed to er (R1) assisted living with the required verified asservices at the facil.  This practice result violation that did not safety but had the president's health or cause serious injurits issued at a wides are pervasive or rephas affected or has portion or all of the The findings include R1's diagnoses include R1's	re agent"), if applicable."  Ist contain a page or space for act information of the ntative and a box the resident sident declines to name a ntative. Notwithstanding graph (f), the resident has the add, remove, or change the nformation of the designated ent is not met as evidenced and record review, the nsure one of one resident's contract included a notice erbiage for the residents to d representative. This had the II 17 residents who received ity.  Bed in a level two violation (a tharm a client's health or potential to have harmed a safety, but was not likely to y, impairment, or death), and appread scope (when problems present a systemic failure that the potential to affect a large clients).  Be:  Uded hypertension, diabetes, citive pulmonary disease struction of lung airflow that hal breathing).	0 950			
	KT's service plan d	ated March 14, 2022,				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED	
		30550	B. WING		08/	23/2022
	PROVIDER OR SUPPLIER  S CARE INCORPORA	702 7TH	DDRESS, CITY, S STREET SW , MN 56751	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE LE APPROPRIATE	(X5) COMPLETE DATE
0 950	indicated the reside services: medicatio setup, assistance will blood glucose monicompression stocki laundry.  R1's Resident Agreincluded a Designal listed a name and procession stocki laundry.  R1's Resident Agreincluded a Designal listed a name and procession stocki laundry.  R1's Resident Agreincluded a Designal listed a name and procession stocki laundry.  On August 23, 2022 nurse/licensed assi (RN/LALD)-A stated Representative form provided to all residuanted as their designated Represedid not contain all the written in statute redesignate a represedidated August 1, 2020 of execution of an allot of facility] must offer identify a designate the contract and mulicipal residuanted an	ent received the following in administration, medication with bathing, oxygen therapy, itoring, application/removal of ings, housekeeping, and ement dated August 1, 2021, ted Representative form which shone number of R1's intative. The Designated in did not contain the language in the statute regarding the esignate a representative.  2, at 12:02 p.m., registered is the Designated in was a template form lents to identify who they signated representative. After a e, RN/LALD-A confirmed the entative form they were using the language required as garding the resident's right to				
	No further informati	·				
	TIME PERIOD FOR	R CORRECTION: Twenty-One				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		30550	B. WING		08/2	3/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AGELES	S CARE INCORPORA	TFD	STREET SW , MN 56751			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
0 950	Continued From pa	ge 26	0 950			
	(21) days					
0 970 SS=C	The contract must reliability for the healt property of a reside include any provision should know to be connenforceable unde	not include a waiver of facility h and safety or personal nt. The contract must not on that the facility knows or deceptive, unlawful, or er state or federal law, nor on that requires or implies a	0 970			
	lesser standard of or required by law.  This MN Requirement by: Based on interview licensee failed to en contract did not incl facility's liability for l	and record review, the assisted living ude language waiving the nealth, safety, or personal nt. This had the potential to				
	This practice result violation that has no a minimal impact or affect health or safe widespread scope (or represent a system).	ed in a level one violation (a potential to cause more than the resident and does not ety) and was issued at a (when problems are pervasive emic failure that has affected to affect a large portion or all				
	The findings include	e:				
	2022, at 12:15 p.m.	e conference on August 22, , the surveyor asked for a assisted living contract.				
	The assisted living	contract provided included a				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		30550	B. WING		08/23/2022		
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	1		
AGELES	S CARE INCORPORA	TED .	TREET SW MN 56751				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
0 970	facility's liability for property of the residuability of [name of Loses or Damages indicated the client the apartment, the [name of facility] an assume all risk ass further acknowledg liable to the client or loss or damage to presult of intentional applicable standard.  On August 23, 2022 assisted living direct facility provided the contract to all residuability section could see how this in a way that did no RN/LALD-A stated section out of the author to the licensee's Assidated August 1, 2021 not include a waive health and safety or No further information.	and the resident would waive the health, safety, or personal dent. Page 14, section No facility] for Certain Other of the assisted living contract acknowledges familiarity with premises and services of a dis therefore willing to, does ociated with occupancy. Client es that the landlord is not a to any other person for any property, which is not a direct or negligent acts in violation of dis of care.  2. at registered nurse/licensed ctor (RN/LALD)-A stated the same template assisted living ents. RN/LALD-A reviewed the of the contract and stated she language could be interpreted at meet the regulation. I will probably just take that ssisted living contract.  Sted Living Contract policy 21, noted the contract must of facility liability for the repersonal property of a client.	0 970				
01470 SS=E	144G.63 Subd. 2 C	ontent of required orientation	01470				
	(a) The orientation	must contain the following					

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Minnesc	<u>ota Department of He</u>	ealth				
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		30550	B. WING		08/2	3/2022
NAME OF		CTDEET AS	DDESS CITY S	STATE ZID CODE		
NAIVIE OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
AGELES	S CARE INCORPORA	TFD	STREET SW , MN 56751			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
01470	Continued From pa	ge 28	01470			
	topics: (1) an overview of t (2) an introduction a policies and proced of assisted living se person; (3) handling of eme emergency services (4) compliance with maltreatment of vul 626.557 to the Minr Center (MAARC); (5) the assisted livin responsibilities rela and protection of th (6) the principles of and service delivery support services pr (7) handling of resic complaints, and wh including information Facility Complaints; (8) consumer advoid Ombudsman for Lo Ombudsman for Lo Ombudsman for Lo Ombudsman at the Services, county-m other relevant advoid (9) a review of the te services the employ facility's category of (b) In addition to the orientation may also services to resident training on hearing subdivision must be	his chapter; and review of the facility's lures related to the provision ervices by the individual staff ergencies and use of s; and reporting of the nerable adults under section nesota Adult Abuse Reporting ng bill of rights and staff ted to ensuring the exercise ose rights; person-centered planning y and how they apply to direct ovided by the staff person; dents' complaints, reporting of ere to report complaints, on on the Office of Health cacy services of the Office of ental Health and abilities, Managed Care Department of Human anaged care advocates, or cacy services; and types of assisted living types of assisted living types will be providing and the				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		30550	B. WING		08/2	3/2022
NAME OF PROVIDER OR	SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AGELESS CARE INC	CORPORA	ATED	MN 56751			
PREFIX (EACH	DEFICIENC'	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
and how it the challet (2) health age-relate incidence isolation, a (3) informathat may e involveme assistive I and tactile access in This MN F by: Based on review, the assisted li content for personnel (LPN)-E), This pract violation the safety but resident's pattern so of residen number of occurred in pervasive. The findin ULP-D ULP-D was	planation of the manifes and depression about the manifes of demendent and depression and depression about the manifest of the	of age-related hearing loss ts itself, its prevalence, and oses to communication; related to untreated gloss, such as increased intia, falls, hospitalizations, ession; or ut strategies and technology communication and ling communication strategies, devices, hearing aids, visual devices, communication, and closed captions.  The sent is not met as evidenced in interview and record efailed to ensure orientation to utes included all the required wo employees (unlicensed, licensed practical nurse ords reviewed.  The sent is a level two violation (and the sent is not may be a sent in a level two violation (and the sent is not may be a safety) and was issued at a sent more than a limited number ected, more than a limited involved, or the situation has by; but is not found to be	01470			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		30550	B. WING		08/2	3/2022
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 00/2	3/2022
AGELES	S CARE INCORPORA	TED	STREET SW MN 56751			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
01470	Continued From pa	ge 30	01470			
	ULP-D's employee required orientation - an overview of the					
		n May 15, 2022, to provide ents at the assisted living				
		2, at 10:24 a.m., the surveyor etup R1's weekly medications.				
	LPN-E's employee record lacked the following required orientation content: - overview of the 144G statutes; and - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person					
	nurse/licensed ass (RN/LALD)-A review employee records a	2, at 2:27 p.m., registered isted living director wed ULP-D and LPN-E's and stated ULP-D and LPN-E the above noted orientation as				
		sonnel Records policy dated each employee record would tion of orientation.				
	No further informat	ion was provided.				
	TIME PERIOD FOI (21) days	R CORRECTION: Twenty-One				
01530 SS=E		G IN DEMENTIA CARE	01530			

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AND PLAN OF CORRECTION   IDENTIFICATION NUMBER:   A. BUILDING:   COMPLETED    30550   B. WING   08/23/202    NAME OF PROVIDER OR SUPPLIER   STREET ADDRESS, CITY, STATE, ZIP CODE    702 7TH STREET SW   ROSEAU, MN 56751	winnesc	ota Department of He	eaim				
NAME OF PROVIDER OR SUPPLIER  AGELESS CARE INCORPORATED  STREET ADDRESS, CITY, STATE, ZIP CODE  702 7TH STREET SW  ROSEAU, MN 56751						(X3) DATE SURVEY COMPLETED	
AGELESS CARE INCORPORATED  702 7TH STREET SW ROSEAU, MN 56751			30550	B. WING		08/2	3/2022
AGELESS CARE INCORPORATED ROSEAU, MN 56751	NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	AGELES	SS CARE INCORPORA	NTFD				
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CON		(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	(X5) COMPLETE DATE
01530 Continued From page 31 01530	01530			01530			
(a) All assisted living facilities must meet the following training requirements:  (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter;  (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 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 observation, interview, and record review, the licensee failed to ensure two of three employees (unlicensed personnel (ULP)-D, licensed practical nurse (LPN)-E) received the required amount of dementia care training in the required time frame with records reviewed. This had the potential to affect all residents.  This practice resulted in a level two violation (a violation that did not harm a resident's health or		following training re (1) supervisors of deast eight hours of specified under par hours of the employ have at least two horelated to demential employment therea (2) direct-care employment therea (2) direct-care employment it least eight hours specified under par hours of the employinitial training is corprovide direct care employee on site weight hours of training dementia care and and assist if issues requirements under meeting the require available for consuluntil the training reconsuluntil the training on each 12 months of the mount of training on each 12 months of the mount of required amount of required time frame had the potential to the mount of the mou	equirements: direct-care staff must have at initial training on topics agraph (b) within 120 working yment start date, and must ours of training on topics acare for each 12 months of offer; loyees must have completed of initial training on topics agraph (b) within 160 working yment start date. Until this implete, an employee must not unless there is another who has completed the initial ing on topics related to who can act as a resource arise. A trainer of the reparagraph (b) or a supervisor ements in clause (1) must be station with the new employee quirement is complete. It is not met as evidenced at the initial for employment thereafter;  ent is not met as evidenced at an interview, and record a failed to ensure two of three is sed personnel (ULP)-D, urse (LPN)-E) received the dementia care training in the exist would resident and residents.				

Minnesota Department of Health

safety but had the potential to have harmed a

STATE FORM 6899 If continuation sheet 32 of 45 J12I11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		30550	B. WING		08/2	23/2022
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
AGELES	S CARE INCORPORA	ATED	STREET SW , MN 56751			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
01530	resident's health or pattern scope (whe of residents are affinumber of staff are occurred repeatedly pervasive).  The findings included the finding facility.  ULP-D was hired or provide direct care living facility.  ULP-D's employee of 8 hours of the recompleted within 10 direct care to reside facility.  On August 23, 2023 observed LPN-E semployee of 8 hours of the recompleted within 10 start date. LPN-E's hours of demential facility.	resafety) and was issued at a en more than a limited number ected, more than a limited involved, or the situation has y; but is not found to be  e:  In November 22, 2021, to to to residents at the assisted  record did not indicate a total quired dementia training was 60 hours of the employee's employee record indicated the pleted 6.5 hours of dementia  In May 15, 2022, to provide ents at the assisted living  2, at 10:24 a.m., the surveyor etup R1's weekly medications.  record did not indicate a total quired dementia training was 60 hours of the employee's employee record had zero training completed.  2, at 2:30 p.m., registered	01530	DEFICIENCY)		
	education records a	wed ULP-D and LPN-E's and stated she thought ULP-D he dementia training that was				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			
		30550	B. WING		08/2	3/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AGELES	S CARE INCORPORA	ATFD	STREET SW MN 56751			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
01530	required but she ca hours. RN/LALD-A had not completed went on to say the adopting an online and running yet.  The licensee's Staf policy dated June 1 provided training re Staff providing or s Alzheimer's Diseas care.  No further informat TIME PERIOD FOR (21) days	an see ULP-D was short 1.5 stated she was aware LPN-E her dementia training and licensee is in the process of education system that isn't up of Orientation and Education 2, 2015, noted the licensee elated to Alzheimer's Disease. Upervising care would receive the education prior to providing	01530			
SS=F	and revisions to  (f) The service plan (1) a description of the fees for service service, according assessment and re (2) the identification who will provide the (3) the schedule an assessments of the (4) the schedule an providing services; (5) a contingency p (i) the action to be t cannot be provided (ii) information and facility;	n must include: the services to be provided, es, and the frequency of each to the resident's current esident preferences; n of staff or categories of staff es services; and methods of monitoring e resident; and methods of monitoring staff and elan that includes: taken if the scheduled service	01030			

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			7. Boileants.			
		30550	B. WING		08/2	3/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AGELES	S CARE INCORPORA	TED	STREET SW MN 56751			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
01650	emergency or if the change in the resididentification of and authority to sign for and (iv) the circumstant medical services ar consistent with chadeclarations made chapters.  This MN Requirements by: Based on interview licensee failed to enthe required content with records review.  This practice results violation that did not safety but had the president's health or widespread scope or represent a system or has the potential of the residents).  The findings include R1's diagnoses included the resident obstruction (COPD-chronic obstruction of the residents) interferes with norm.	to have notified in an re is a significant adverse ent's condition, including information as to who has the resident in an emergency; sees in which emergency end to be summoned pters 145B and 145C, and by the resident under those ent is not met as evidenced and record review, the asure the service plan included at for one of one resident (R1) red.  The din a level two violation (and tharm a resident's health or potential to have harmed a safety) and was issued at a (when problems are pervasive emic failure that has affected to affect a large portion or all estimated to the problems are pervasive emic failure that has affected to affect a large portion or all estimated to form the problems are pervasive emic failure that has affected to affect a large portion or all estimated the problems are pervasive emic failure that has affected to affect a large portion or all estimated the problems are pervasive emic failure that has affected to affect a large portion or all estimated the problems are pervasive emic failure that has affected to affect a large portion or all estimated the problems are pervasive emic failure that has affected to affect a large portion or all estimated the problems are pervasive emic failure that has affected to affect a large portion or all estimated the problems are pervasive emic failure that has affected to affect a large portion or all estimated the problems are pervasive emic failure that has affected to affect a large portion or all estimated the problems are pervasive emic failure that has affected to affect a large portion or all estimated the problems are pervasive emic failure that has affected to affect a large portion or all entered the problems are pervasive emic failure that has affected to affect a large portion or all entered the problems are pervasive emic failure that has affected to affect a large portion or all entered the problems are pervasive emic failure that has affected to affect a large portion or all entered the problems are problems are problems are problems are	01650			

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		30550	B. WING		08/	23/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
AGELES	S CARE INCORPORA	TFD	STREET SW J, MN 56751			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
01650	compression stocki laundry.  R1's service plan direquired content: - the fees for servicing the schedule and assessments of the schedule and providing services; - a contingency plantaken if the schedule provided.  On August 23, 2022 nurse/licensed assi (RN/LALD)-A stated resident is on a wai come across on the RN/LALD-A confirm content was not on stated the same terfor all residents.  The licensee's Servicing plantaken would include the fees for servicing the schedule and assessments of the the schedule and providing services a contingency plantaken if the schedule and providing services a contingency plantaken is on a wai come across on the RN/LALD-A confirm content was not on stated the same terfor all residents.	ings, housekeeping, and id not include the following ies; methods of monitoring resident; methods of monitoring staff and in that included the action to be led service cannot be  2, at 11:43 a.m., registered sted living director d for some reason if the ver program the fees do not resident's service plans. and the above noted required R1's service plan RN/LALD-A mplate service plan was used  vice Plan - Assisted Living at 1, 2021, noted the service the following: the following: the following: the client methods of monitoring staff at that included the action to be led service cannot be				
		·				
	TIME PERIOD FOR (21) days	R CORRECTION: Twenty-One	!			

6899

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		30550	B. WING		08/2	3/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
AGELESS	CARE INCORPORA	TED	TREET SW			
		<u> </u>	MN 56751			I
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
	144G.71 Subd. 10 I residents who will	Medication management for	01790			
	is not able to provide nurse or unlicensed medications in amonthe length of the an exceed seven caler (3) the resident must information on medinstructions for administructions for administructions, includ (4) the medications medication contains the provider's medication such that the result of the registered not unlicensed staff and staff is competent to giving medications (2) the registered not procedures for the registered not procedure for the readdress:  (i) the type of contained for the medications medication system;  (ii) how the contained labeled;  (iii) written information be provided;  (iv) how the unlicense.	st be provided written lications, including any special ninistering or handling the ing controlled substances; and must be placed in a er or containers appropriate to cation system and must be ident's name and the dates medications are scheduled. ime away when the licensed ide, the registered nurse may of unlicensed personnel if: urse has trained the determined the unlicensed of follow the procedures for to residents; and urse has developed written unlicensed personnel, all instructions or procedures disubstances that are esident. The procedures must iner or containers to be used appropriate to the provider's				

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Minnesota Department of Health

	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		30550	B. WING		08/	23/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE ZIP CODE	·	
		702 7TH 9	STREET SW			
AGELES	SS CARE INCORPORA	ATFD	, MN 56751			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
01790	provided, including medications were predications, the permedications to the medications that we and other required (v) how the register medications have be registered nurse neather medications are designated represe (vi) a review by the completion of this to completed accurate personnel; and (vii) how the unlicer document in the resemedications that are including the name doses of each return this MN Requiremedications that are including the name doses of each return this MN Requiremedications, the licensed registered nurse (Reprocedures for the providing medication unplanned time away was not available. It to ensure one of on (ULP-D) were trained competency to prepresidents having until the providing that did not safety but had the president's health or	documenting the date the provided and who received the provided and who received the present who provided the resident, the number of pere provided to the resident, information; and red nurse shall be notified that peen provided and whether the peeds to be contacted before a given to the resident or the pentative; registered nurse of the peak to verify that this task was pely by the unlicensed the personnel must be sident's record any unused the returned to the facility, of each medication and the	01790			

Minnesota Department of Health

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		30550	B. WING		08/	23/2022
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		_
AGELES	S CARE INCORPORA	ATFD	STREET SW , MN 56751			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
01790	are pervasive or re has affected or has portion or all of the The findings includ  During the entrance 2022, at 11:55 a.m. assisted living directlicensee provided reservices to the resiture would prepare residents for unplanual UNPLANNED TIME PROCEDURE FOR The licensee failed for the ULP providinaving unplanned to the ULP providination to the ULP pr	spread scope (when problems present a systemic failure that the potential to affect a large residents).  e:  e: conference on August 22,, registered nurse/licensed ctor (RN/LALD)-A stated the nedication management dents. RN/LALD-A stated the and send medications with nned times away.  ES AWAY POLICY AND R ULP to develop a written procedure ng medications for residents imes away.  lication Management Plan for Home policy revised date indicated for unplanned time or temporary periods when an on supply cannot be obtained or setup by the RN in a timely ay delegate and the ULP can		DETIGIENCY)		
	medication system - written information provided; - how the ULP mus record that medicar					

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU  A. BUILDING:		
		30550	B. WING		08/2	3/2022
	PROVIDER OR SUPPLIER	702 7TH S	DRESS, CITY, S STREET SW MN 56751	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
01790	medications, the permedications to the medications that we and other required - how the RN shall have been provided be contacted before the resident or the - how the ULP mus record any unused to the facility, included to the facility, included to the facility, included medication.  TRAINING AND COULP-D ULP-D was hired or provide direct care which included medications to residually from home.  ULP-D's employee indicate she had be demonstrated commedications to residually from home.  On August 23, 2022 stated the above now written procedure for preparing and giving an unplanned time provides informal transparse and providunplanned times and competency evaluations.	erson who provided the resident, the number of ere provided to the resident, information; be notified that medications d and whether the RN needs to e the medications are given to designated representative; and t document in the resident's medications that are returned ling the name of each doses of each returned.  OMPETENCY EVALUATIONS of the licensee's residents dication administration.  The record lacked evidence to be trained and had be dents for unplanned times.  And the policy did not include a correct of the licensee's residents for unplanned times.  And the policy did not include a correct policy did not residents for away. RN/LALD-A stated she aining to ULP on how to be medications to residents for away but had not completed attions and no training or attions would be recorded in inployee records.	01790			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		30550	B. WING		08/2	3/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AGELES	S CARE INCORPORA	TFD	STREET SW MN 56751			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
01790	Continued From pa	ge 40	01790			
	TIME PERIOD FOR days	R CORRECTION: Seven (7)				
01890 SS=F	144G.71 Subd. 20 F	Prescription drugs	01890			
	immediate or later a the original containe by the pharmacy be label with legible inf	prior to being set up for administration, must be kept in er in which it was dispensed earing the original prescription formation including the d-use date of a time-dated				
	by: Based on observation review, the licensees were maintained with the expiration date.	ent is not met as evidenced on, interview, and record e failed to ensure medications th legible information including for time sensitive medications ent (R1) with records				
	violation that did no safety but had the p resident's health or widespread scope ( or represent a syste	ed in a level two violation (a t harm a resident's health or octential to have harmed a safety) and was issued at a when problems are pervasive emic failure that has affected to affect a large portion or all				
	The findings include	<b>Э</b> :				
	observed unlicense administer R1's sch included administra insulin. R1's Humal	2, at 11:23 a.m., the surveyor d personnel (ULP)-B neduled medications which tion of 13 units of Humalog og 100 units/milliliter (ml) tus 100 units/ml insulin pen				

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Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			7. 55.25II.G.				
		30550	B. WING		08/2	3/2022	
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
AGELES	S CARE INCORPORA	(TFD)	STREET SW MN 56751				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
01890	Continued From pa	ge 41	01890				
		which indicated the date the en opened and when the expire.					
		2, at 11:33 a.m., ULP-B stated ir insulin pens when they are					
	nurse/licensed assi (RN/LALD)-A stated be dated with a date would expire. RN/L facility's practice to are opened as she	2, at 12:40 p.m., registered sted living director d R1's insulin pens would not e when opened or when they ALD-A stated it wasn't the date insulin pens when they figures the resident's gopens so quickly, they wouldn't					
	pens dated Decem	instructions for Lantus insulin per 2019, directed to discard er it had been opened, even if t in it.					
	insulin pens dated A	instructions for Humalog April 2020, directed to discard er it had been opened, even if t in it.					
	Medications policy	age of Client's Personal dated September 13, 2019, bels should contain an ime-dated drugs.					
	No further informati	on was provided.					
	TIME PERIOD FOR days	R CORRECTION: Seven (7)					

6899

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		30550	B. WING		08/	23/2022	
	PROVIDER OR SUPPLIER	702 7TH S	DRESS, CITY, ST STREET SW MN 56751	TATE, ZIP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
02310	Continued From pa	ge 42	02310				
02310 SS=D	144G.91 Subd. 4 A	ppropriate care and services	02310				
	living services that resident's needs ar	the right to care and assisted are appropriate based on the ad according to an up-to-date t to accepted health care					
	by: Based on observatifailed to provide cathe acceptable hea	ent is not met as evidenced on and interview, the licensee re and services according to lth care medical or nursing e safe storage of oxygen.					
	violation that did no safety but had the p resident's health or cause serious injur- was issued at an is limited number of a limited number of	ed in a level two violation (a tharm a resident's health or potential to have harmed a safety, but was not likely to y, impairment, or death), and olated scope (when one or a esidents are affected or one or staff are involved or the red only occasionally).					
	The findings include	e:					
	observed in R1's be cylinders and two to oxygen cylinders ar cylinders were secu other tall oxygen cy on the floor in an up	2, at 11:35 a.m., the surveyor edroom 24 short oxygen all oxygen cylinders. The short one of the tall oxygen ured in a holder/stand. The dinder was positioned directly oright position in the corner or gen cylinder was not securely r stand.					
	nurse/licensed assi	2, at 12:36 p.m., registered sted living director ed R1's room with the					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		30550	B. WING		08/2	3/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AGELES	S CARE INCORPORA	TFD	STREET SW , MN 56751			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
02310	surveyor present. Foxygen cylinder was and stated it should stated she would go oxygen cylinder.  The licensee's Oxygname] policy dated licensee would provuse of oxygen in the No further information	RN/LALD-A confirmed the one is not securely being stored to be in stand. RN/LALD-A set a holder for the unsecure gen/Nebulizer Use at [facility October 21, 2019, noted the wide a safe environment for the se home.	02310			
03090 SS=C	Subd. 8.Notice to via sign at each facility visitors that states: devices, including states devices, may be preactivities."  (b) The facility is remaintaining the sign subdivision.  This MN Requirements: Based on observatificated to ensure sign entryway of the estate language to discloss activity, potentially a and visitors of the liest sign and visitors of the liest si	isitors. (a) A facility must post ty entrance accessible to "Electronic monitoring recurity cameras and audio resent to record persons and responsible for installing and reage required in this rent is not met as evidenced on and interview, the licensee reage was posted at the main ablishment to display statutory e electronic monitoring affecting all 19 residents, staff,	03090			

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		30550	B. WING		08/2	3/2022
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
AGELES	S CARE INCORPORA	NTFD	STREET SW MN 56751			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
03090	violation that has not a minimal impact or affect health or safe widespread scope or represent a syste or has the potential the residents).  The findings include On August 22, 2022 entered the facility, in the entryway of the monitoring devices.  On August 22, 2022 nurse/licensed assi (RN/LALD)-A stated have any video can RN/LALD-A stated signage posted in the electronic monitoring stated she was not for everyone.  No further information	o potential to cause more than in the resident and does not ety) and was issued at a (when problems are pervasive emic failure that has affected to affect a large portion or all e:  2, at 10:30 a.m., the surveyor There was no signage posted he facility regarding electronic et al.  2, at 12:23 p.m., registered sted living director did the licensee currently did not heras in or around the facility. The licensee did not have he entryway regarding as required. RN/LALD-A aware this was a requirement	03090			

6899



Minnesota Department of Health Food, Pools and Lodging Services PO Box 64975 St. Paul, MN 55164-0975 651-201-4500

Type: Full
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Time: 10:00:49
Report: 1002221167

# Food and Beverage Establishment Inspection Report

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	ca		

Ageless Care Incorporated

702 7th Street Sw Roseau, MN56751 Roseau County, 68

## License Categories:

Expires on: //

### Establishment Info:

ID#: 0039095

Risk:

Announced Inspection: Yes

### Operator:

Phone #: 2184633695

ID #:

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

The following orders were issued during this inspection.

## 2-100 Supervision

### 2-103.11EF

\*\* Priority 2 \*\*

MN Rule 4626.0035EF The person in charge must ensure employees verify food delivered and received at the facility is: obtained from approved sources; delivered at required temperatures; protected from contamination, and adulteration. Food received during non-operating hours must meet the standards identified above and must be properly stored, including if necessary refrigerated.

ESTABLISHMENT WAS UNAWARE OF THE REQUIREMENT TO TAKE RECEIVING TEMPERATURES OF FOOD THAT IS DELIVERED FROM OTHER SOURCES. DISCUSSED REQUIREMENT WITH OPERATOR AS WELL AS CORRECTIVE ACTIONS IN THE EVENT OF TEMPERATURE ABUSE.

Comply By: 08/23/22

## 4-300 Equipment Numbers and Capacities

### 4-302.14

\*\* Priority 2 \*\*

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

NO SANITIZER TEST KIT AVAILABLE AT TIME OF INSPECTION TO MEASURE THE CHLORINE CONCENTRATION OF THE SANITIZER SOLUTION. OPERATOR INDICATED THE TEST STRIPS HAVE BEEN ORDERED.

Comply By: 08/30/22

### 4-500 Equipment Maintenance and Operation

### 4-502.11B

\*\* Priority 2 \*\*

MN Rule 4626.0820B Calibrate food temperature measuring devices in accordance with manufacturer's specifications as often as necessary to ensure accuracy.

THE THERMOMETER BEING UTILIZED WAS NOT ACCURATE. ATTEMPTS TO CALIBRATE

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## Food and Beverage Establishment Inspection Report

THE THERMOMETER AT TIME OF INSPECTION WERE UNSUCCESSFUL. DISCUSSED THERMOMETER CALIBRATION METHOD AND FREQUENCY WITH OPERATOR.

Comply By: 08/30/22

## 5-200A Plumbing: approved materials/design

5-203.11A

\*\* Priority 2 \*\*

MN Rule 4626.1070A Provide at least 1 handwashing sink, or the number of handwashing sinks necessary to allow for the convenient use by employees during food preparation, food dispensing, and warewashing; and in or adjacent to toilet rooms.

ESTABLISHMENT CURRENTLY DOES NOT HAVE A DESIGNATED HANDSINK IN THE FOOD SERVICE AREA. SEE COMMENT SECTION FOR DETAILS.

Comply By: 10/23/22

## 2-100 Supervision

#### 2-102.12AMN

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

THIS ESTABLISHMENT DOES NOT HAVE A DESIGNATED CFPM. COURSE INFORMATION WAS PROVIDED TO OPERATOR. SEE COMMENT SECTION FOR DETAILS.

Comply By: 10/23/22

## **Surface and Equipment Sanitizers**

Chlorine: = 100 PPM at Degrees Fahrenheit

Location: SANITIZER SOLUTION

Violation Issued: No

### **Food and Equipment Temperatures**

Process/Item: Upright Cooler

Temperature: 39 Degrees Fahrenheit - Location: BROCCOLI CHEESE SOUP - FRIGIDAIRE COOLER

Violation Issued: No

Process/Item: Upright Freezer

Temperature: 0 Degrees Fahrenheit - Location: AMBIENT TEMP - FRIGIDAIRE FREEZER

Violation Issued: No

Process/Item: Upright Cooler

Temperature: 38 Degrees Fahrenheit - Location: BUTTER - STORAGE COOLER

Violation Issued: No

Process/Item: Upright Freezer

Temperature: 0 Degrees Fahrenheit - Location: AMBIENT TEMP - STORAGE FREEZER

Violation Issued: No

Process/Item: Re-Heating

Temperature: 157 Degrees Fahrenheit - Location: SOUP - REHEATING IN CROCK POT @ 1 HR 15

**MINS** 

Violation Issued: No

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## Food and Beverage Establishment Inspection Report

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	4	1

Discussion:

Handwashing - fact sheets and sign provided with report

Employee illness - fact sheet, decision guide and log provided with report

Safe cleaning, sanitizing and manual warewashing - fact sheet and sign provided with report

Food service among highly susceptible populations - fact sheet provided with report

Safe times & temps of TCS food/re-heating - fact sheet provided with report

CFPM - fact sheet, application and course information was provided to operator in a separate correspondence

Thermometer calibration - method and frequency

### Notes:

Assisted living facilities are exempt from the requirement to have a commercial kitchen as long as the food is being prepared for immediate service (also known as cook-serve). This means that the menu cannot include food that requires complicated cooking procedures including cooling. Please note that if an establishment wishes to offer menu items that are beyond the limitations of the exemption, a commercial kitchen would be required. There are also other food safety requirements for facilities who serve food to highly susceptible populations. A fact sheet was provided with the report.

This assisted living facility currently receives Monday-Friday lunch meals 2x per week from Twin's Cafe in Badger. The meals arrive cold and require re-heating by the establishment. The facility prepares breakfast and dinner daily for residents on site, as well as weekend meals. Based on this information, MDH determined that this facility conducts food preparation and thus requires a designated certified food protection manager (CFPM). Please note that MN statute requires that this violation be corrected within 60 days which means that the comply-by date for this specific issue is 23 October 2022.

Assisted living facilities are required to provide an approved method for cleaning and sanitizing dishes and utensils. Currently, this establishment only has a domestic two-compartment sink which does not meet the requirement for proper warewashing procedures. Corrective action options are being discussed with the operator but in the meantime, the establishment must immediately begin using a bin or basin to serve as a 3rd sink bay to allow for each step of the warewashing process (WASH - RINSE - SANITIZE - AIR DRY). Please note that the use of this basin is a temporary fix and that this issue must be resolved. The timeline will depend on the changes that are to be made and further discussion with the operator is needed before a comply-by date is assigned for this specific issue.

Assisted living facilities are also required to provide a designated handwash sink within the food service area. The establishment is currently using the handwash sink located within the restroom. Please note that a restroom sink cannot be dual-purposed as a food service sink. Corrective action options are being discussed with the operator but in the meantime, the establishment must wash their hands in the wash bay of the existing two compartment sink. Be sure to clean and sanitize the sinks before and after using them for warewashing. Please note that this is a temporary fix and that a designated handwash sink will be

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# Food and Beverage Establishment Inspection Report

required. Again, the timeline will depend on the changes that are to be made and further discussion with the operator is needed before a comply-by date is assigned for this specific issue.

Please note that any plumbing changes that occur must be completed by a licensed plumber. The plumber is responsible for filing plumbing plans with the MN Dept of Labor and Industry (DLI). All work must be inspected and approved by the plumbing inspector prior to use.

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

number 1002221167 of 08/23/22.

Certified Food Protection Manager: NONE

Certification Number: \_\_\_\_\_ Expires: \_\_/ /

Inspection report reviewed with person in charge and emailed.

Signed: \_\_\_\_\_ Signed: \_\_\_\_\_

I acknowledge receipt of the Minnesota Department of Health inspection report

Shawny Elyk-Prevost Owner/Operator

Cassandra Hua
Public Health Sanitarian III

218-308-2142

Cassandra. Hua@state.mn. us

Report #: 10022211	67	Food Establis	hm	er	nt Ir	nsr	ection	n Repo	rt				
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Ageless Care Incorpo	orated	Address		_	Cit	y/Stat	_	•	Zip Code	Tele	phone		
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License/Permit # 0039095		Permit Holder			<b>Pu</b> i Fu	•	of Inspection	on	Est Type		Risk Catego	ry	
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16   IN OUT N/A   17   IN OUT   N/A   17   IN OUT   N/A   30   IN OUT N/A   31   Water & 32   IN OUT N/A   35   IN OUT N/A   36   X   Thermome   37   Food propagation   Food Recalls:	Food separated and Food contact surfar Proper disposition reconditioned, & under the surface of	m Contamination d protected ces: cleaned & sanitized of returned, previously served, isafe food  GOO are preventative measures to control in compliance Mark "X"  d Water s used where required approved source for specialized processing methods re Control adequate equipment for berly cooked for hot holding ring methods used urate fication container d Contamination present g food prep, storage & display	the ac	dditic propr	## Previous	RAC athoge	TICES ens, chemica COS and/or F  Utensils, et Single-use, Gloves use  Food & not designed, o Warewash Non-food o  Hot & cold Plumbing it Sewage & Toilet facilit Garbage & Physical fa Adequate o Compliance	ls, and physica R COS=  Proposition of south and physical R COS=  Propos	all objects into food corrected on-site du er Use of Utensil stored ens: properly store articles: properly: quipment and Ve surfaces cleanabl used stalled, maintaine s clean eysical Facilities e; adequate press r backflow device: roperly disposed onstructed, suppli y disposed; facilities d, maintained, & c hting; designated	s. ring insp  s ed, driece stored & ending e, prope d, & use ure s ed, & cl es mair lean	ection R= repe	at violar	ition
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