



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered

May 2, 2023

Licensee  
Lakeview Senior Housing  
651 US Highway 14 East  
Balaton, MN 56115

RE: Project Number(s) SL35521015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 13, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

#### **STATE CORRECTION ORDERS**

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

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

#### **DOCUMENTATION OF ACTION TO COMPLY**

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

The correction order documentation should include the following:

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

**CORRECTION ORDER RECONSIDERATION PROCESS**

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

A state correction 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 reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

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

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

If you have any questions, please contact me.

Sincerely,



Jodi Johnson, Superviso  
State Evaluation Team  
Email: [jodi.johnson@state.mn.us](mailto:jodi.johnson@state.mn.us)  
Telephone: 507-344-2730 Fax: 651-281-9796

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>35521</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/13/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>LAKEVIEW SENIOR HOUSING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>651 US HIGHWAY 14 EAST BALATON, MN 56115</b>
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0 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.</p> <p>Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.</p> <p>INITIAL COMMENTS: SL#35521015</p> <p>On April 11, 2023, through April 13, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 14 active residents receiving services under the Assisted Living license.</p>	0 000	<p>Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction.</p> <p>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.</p>	
0 430 SS=C	<p>144G.40 Subd. 2 Uniform checklist disclosure of services</p> <p>(a) All assisted living facilities must provide to</p>	0 430		

Minnesota Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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0 430	<p>Continued From page 1</p> <p>prospective residents:                      (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility;                      (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and                      (3) an oral explanation of the services offered under the contract.                      (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract.                      (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a).</p> <p>This MN Requirement is not met as evidenced by:                      Based on interview and record review, the licensee failed to identify the correct license on the Uniform Disclosure of Assisted Living Service and Amenities (UDALSA) for two of two residents. (R2, R3).</p> <p>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).</p> <p>The findings include:</p> <p>R2 began receiving services under the assisted</p>	0 430		

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0 430	<p>Continued From page 2</p> <p>living license on August 1, 2022.</p> <p>R3 began receiving services under the comprehensive home care license on October 1, 2019, and under the assisted living license on August 1, 2021.</p> <p>R2 and R3's record included a UDALSA stating on page 2, under "Facility/Campus listed above has the following license. Check one: Assisted Living Facility with Dementia Care License."</p> <p>R2 and R3's record lacked evidence the correct license was identified on the UDALSA provided to the resident.</p> <p>On April 13, 2023, at 10:57 a.m. licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B verified R2 and R3's UDALSA failed to disclose the correct category of the assisted living license as an assisted living facility (ALF). All resident contracts were the same and identified the licensee as having an assisted living facility with dementia care instead of an ALF.</p> <p>The licensee's Uniform Disclosure of Assisted Living Services and Amenities policy dated August 1, 2021, indicated the community UDALSA will disclose the category of license held and will list all the services and amenities permitted under the community's license.</p> <p>No further information provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-One (21) days</p>	0 430		

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0 480  0 480 SS=F	Continued From page 3  144G.41 Subd 1 (13) (i) (B) Minimum requirements  (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and  This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code.  This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).  The findings include:  Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated April 11, 2023, for the specific Minnesota Food Code deficiencies.  TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480  0 480		
0 650 SS=D	144G.42 Subd. 8 Employee records  (a) The facility must maintain current records of each paid employee, each regularly scheduled	0 650		

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0 650	<p>Continued From page 4</p> <p>volunteer providing services, and each individual contractor providing services. The records must include the following information:</p> <p>(1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules;</p> <p>(2) records of orientation, required annual training and infection control training, and competency evaluations;</p> <p>(3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision;</p> <p>(4) documentation of annual performance reviews that identify areas of improvement needed and training needs;</p> <p>(5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and</p> <p>(6) documentation of the background study as required under section 144.057.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of two employees' records (clinical nurse supervisor (CNS)-B) included the required content.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).</p>	0 650		

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0 650	<p>Continued From page 5</p> <p>The findings include:</p> <p>CNS-B's employee record lacked evidence an annual performance review was completed.</p> <p>CNS-B was hired on October 10, 2019, to provide direct care services to the licensee's residents.</p> <p>On April 13, 2023, at 1:40 p.m. director of operations (DO)-F confirmed CNS-B's employee record did not include an annual performance review.</p> <p>The licensee's Personnel Files Employee Records policy dated November 1, 2019, indicated the content of employee records included documentation of annual performance review which identify areas of improvement and training recommendations.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-One (21) days</p>	0 650		
0 790 SS=F	<p>144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment</p> <p>(2) install and maintain portable fire extinguishers in accordance with the State Fire Code;</p> <p>(3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and</p>	0 790		



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0 790	<p>Continued From page 6</p> <p>This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to verify that each fire extinguisher was visually checked for a charge and that a professional inspection/maintenance was documented annually.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>Findings include:</p> <p>On a facility tour on April 13, 2023, at approximately 10:45 a.m. with Chief Executive Officer (CEO)-E, it was observed that the fire extinguishers throughout the facility, had an annual maintenance tag with a date of September 2020, indicating that annual and monthly inspections had not been performed as required. During interview, CEO-E indicated that the building was purchased in 2020 and thought these inspections had been done. Maintenance records were requested to verify compliance but were not provided. Annual and monthly inspections of the fire extinguishers are required by NFPA standards and Minnesota State Fire Code to ensure that all systems are maintained and remain in working order.</p>	0 790		

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0 790	Continued From page 7  On April 13, 2023, at approximately 12:15 p.m., CEO-E verbally confirmed survey staff observations.  No further information provided.  TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment  (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.  This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide current tags and documentation of annual inspections of the automatic fire sprinkler system. This deficient condition had the ability to affect all staff and residents.  This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents).  Findings include:	0 800		

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0 800	<p>Continued From page 8</p> <p>On a facility tour on April 13, 2023, at approximately 10:45 a.m. with Chief Executive Officer (CEO)-E, it was observed that the fire sprinkler riser had an annual maintenance tag indicating that annual inspections had not been performed since 2019. During interview, CEO-E indicated that the building was purchased in 2020 and thought they had inspections in the meantime. Maintenance records were requested to verify compliance but were not provided. Annual inspections of the automatic fire sprinkler system are required by NFPA standards and Minnesota State Fire Code to ensure that all systems are maintained and remain in working order.</p> <p>On April 13, 2023, at approximately 12:15 p.m., LALD-B verbally confirmed survey staff observations.</p> <p>No further information provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	0 800		
0 810 SS=F	<p>144G.45 Subd. 2 (b)-(f) Fire protection and physical environment</p> <p>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:</p> <ul style="list-style-type: none"> <li>(1) location and number of resident sleeping rooms;</li> <li>(2) employee actions to be taken in the event of a fire or similar emergency;</li> <li>(3) fire protection procedures necessary for residents; and</li> <li>(4) procedures for resident movement,</li> </ul>	0 810		

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0 810	<p>Continued From page 9</p> <p>evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation.</p> <p>(c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter.</p> <p>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.</p> <p>(e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year.</p> <p>(f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.</p> <p>This MN Requirement is not met as evidenced by: Based on a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements, failed to provide required employee and resident training on fire safety and evacuation, and failed to conduct required evacuation drills. This had the potential to affect all staff, residents, and visitors.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when</p>	0 810		

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0 810	<p>Continued From page 10</p> <p>problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>Findings include:</p> <p>A record review and interview were conducted on April 13, 2023, at approximately 11:45 a.m. with Chief Executive Officer (CEO)-E and Licensed Assisted Living Director (LALD)-A on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility.</p> <p>Record review of the available documentation indicated that the licensee did not have employee actions to be taken in the event of a fire or similar emergency. The facility plan indicated to use RACE acronym but was very vague and did not provide complete actions for employees to take in the event of a fire or similar emergency.</p> <p>Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan.</p> <p>Record review of the available documentation indicated that the fire safety and evacuation plan did not include procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. The facility plan did include some provisions for relocation of residents but did not specify how to move or evacuate residents or identify the unique and unusual needs of the residents.</p> <p>Record review of available documentation</p>	0 810		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>35521</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/13/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>LAKEVIEW SENIOR HOUSING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>651 US HIGHWAY 14 EAST BALATON, MN 56115</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	<p>Continued From page 11</p> <p>indicated that the licensee did not provide employee training on the fire safety and evacuation plan twice per year after the training it initial hire.</p> <p>Record review of the available documentation indicated that the licensee did not provide annual training to residents who can assist in their own evacuation on the proper actions to take in the event of a fire to include movement, evacuation, or relocation as required by statute.</p> <p>Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month as required by statute. Provided documentation indicated that the only drills were not conducted every other month and failed to provide two drills on second shift and two drills on third shift.</p> <p>During interview, CEO-E and LALD verified that the fire safety and evacuation plan for the facility lacked these provisions.</p> <p>No further information provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p>	0 810		
0 920 SS=C	<p>144G.50 Subd. 2 (c) Contract information</p> <p>(c) The contract must include:</p> <p>(1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license;</p> <p>(2) a description of all the terms and conditions of</p>	0 920		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>35521</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/13/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>LAKEVIEW SENIOR HOUSING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>651 US HIGHWAY 14 EAST BALATON, MN 56115</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 920	<p>Continued From page 12</p> <p>the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount;</p> <p>(3) a delineation of the cost and nature of any other services to be provided for an additional fee;</p> <p>(4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract;</p> <p>(5) a delineation of the grounds under which the resident may be transferred or have housing or services terminated or be subject to an emergency relocation;</p> <p>(6) billing and payment procedures and requirements; and</p> <p>(7) disclosure of the facility's ability to provide specialized diets.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee's contracts failed to identify the license held an Assisted Living Facility (ALF) license as required for two of two residents (R2, R3).</p> <p>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).</p> <p>The findings include:</p> <p>R2 R2's Service Plan Addendum dated March 21,</p>	0 920		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>35521</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/13/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>LAKEVIEW SENIOR HOUSING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>651 US HIGHWAY 14 EAST BALATON, MN 56115</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 920	<p>Continued From page 13</p> <p>2023, indicated services included assistance with bathing, grooming, blood glucose monitoring, blood pressure monitoring and medication administration.</p> <p>R2's Assisted Living Contract dated August 1, 2022, failed to disclose the category of the assisted living license as an ALF.</p> <p>R3 R3's Service Plan Addendum dated March 20, 2023, indicated services included bathing, grooming, blood pressure monitoring, compression socks and medication administration.</p> <p>R4's Assisted Living Contract dated August 1, 2022, failed to disclose the category of the assisted living license as an ALF.</p> <p>On April 13, 2023, at 10:57 a.m. licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B verified the above resident contracts failed to disclose the category of the assisted living license as an ALF. All resident contracts were the same and identified the licensee as having an assisted living facility with dementia care instead of an ALF.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-One (21) days</p>	0 920		
0 930 SS=C	<p>144G.50 Subd. 2 (d-e; 1-4) Contract information</p> <p>(d) The contract must include a description of the facility's complaint resolution process available to</p>	0 930		



Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>35521</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/13/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>LAKEVIEW SENIOR HOUSING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>651 US HIGHWAY 14 EAST BALATON, MN 56115</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 930	<p>Continued From page 14</p> <p>residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints.</p> <p>(e) The contract must include a clear and conspicuous notice of:</p> <p>(1) the right under section 144G.54 to appeal the termination of an assisted living contract;</p> <p>(2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer;</p> <p>(3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints;</p> <p>(4) the resident's right to obtain services from an unaffiliated service provider;</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content for two of two residents (R2, R3).</p> <p>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).</p> <p>The findings include:</p> <p>R2</p>	0 930		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>35521</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/13/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>LAKEVIEW SENIOR HOUSING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>651 US HIGHWAY 14 EAST BALATON, MN 56115</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 930	<p>Continued From page 15</p> <p>R2 began receiving services under the assisted living license on August 1, 2022.</p> <p>R2's record included an Assisted Living Contract signed August 1, 2022. The contract lacked a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints.</p> <p>R3</p> <p>R3 began receiving services under the comprehensive home care license on October 1, 2019, and under the assisted living license on August 1, 2021.</p> <p>R3's record included an Assisted Living Contract signed August 1, 2022. The contract lacked a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints.</p> <p>On April 13, 2023, at 1:40 p.m. licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B verified R2 and R3's contract did not include the above noted required content. LALD-A verified all residents received the same contract.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-One (21) days</p>	0 930		
01060 SS=F	144G.52 Subd. 9 Emergency relocation	01060		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>35521</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/13/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>LAKEVIEW SENIOR HOUSING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>651 US HIGHWAY 14 EAST BALATON, MN 56115</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01060	<p>Continued From page 16</p> <p>(a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination.</p> <p>(b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum:</p> <ol style="list-style-type: none"> <li>(1) the reason for the relocation;</li> <li>(2) the name and contact information for the location to which the resident has been relocated and any new service provider;</li> <li>(3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities;</li> <li>(4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and</li> <li>(5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal.</li> </ol> <p>(c) The notice required under paragraph (b) must be delivered as soon as practicable to:</p> <ol style="list-style-type: none"> <li>(1) the resident, legal representative, and designated representative;</li> <li>(2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and</li> <li>(3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days.</li> </ol> <p>(d) Following an emergency relocation, a facility's</p>	01060		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>35521</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/13/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>LAKEVIEW SENIOR HOUSING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>651 US HIGHWAY 14 EAST BALATON, MN 56115</b>
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01060	<p>Continued From page 17</p> <p>refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content to the resident, legal representative, and designated representative, for an emergency relocation for one of two residents (R2).</p> <p>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).</p> <p>The findings include:</p> <p>R2's progress notes identified R2 was hospitalized from March 19, 2023, through March 21, 2023.</p> <p>R2's records lacked evidence the resident and the resident's representative had been provided a written notice as soon as practicable that contained, at a minimum:</p> <ul style="list-style-type: none"> <li>-the reason for the relocation;</li> <li>-the name and contact information for the location to which the resident has been relocated and any new service provider;</li> <li>-contact information for the Office of Ombudsman for Long-Term Care;</li> <li>-if known and applicable, the approximate date or range of dates within which the resident is</li> </ul>	01060		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>35521</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/13/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>LAKEVIEW SENIOR HOUSING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>651 US HIGHWAY 14 EAST BALATON, MN 56115</b>
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01060	<p>Continued From page 18</p> <p>expected to return to the facility, or a statement that a return date is not currently known; and -a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal.</p> <p>On April 13, 2023, at 10:48 a.m. licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated there was no emergency transfer notice completed or provided to the resident or the resident's responsible party. CNS-B stated she only completed the emergency transfer notice if the resident was in the hospital for four or more days.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	01060		



Type: Full
Date: 04/11/23
Time: 12:00:00
Report: 1033231056

Food and Beverage Establishment Inspection Report

Location:

Lakeview Senior Housing
651 Us Highway 14 East
Balaton, MN56115
Lyon County, 42

Establishment Info:

ID #: 0038443
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5077346828
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.

2-300 Personal Cleanliness

2-301.14A \*\* Priority 1 \*\*

MN Rule 4626.0075A Food employees must wash their hands before: food preparation activities, including working with exposed food; touching clean equipment and utensils; touching unwrapped single-service and single-use articles.

Employees do not wash their hands in the serving kitchen before handling clean dishes.

Comply By: 04/11/23

3-500B Microbial Control: hot and cold holding

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

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

Container of whipped butter is stored on the counter at room temperature in the main kitchen. Person in charge disposed of container.

Comply By: 04/11/23

3-800 Highly Susceptible Populations

3-801.11B \*\* Priority 1 \*\*

MN Rule 4626.0447B Discontinue using unpasteurized eggs or egg products in the preparation of Caesar salad, hollandaise or Bearnaise sauce, mayonnaise, meringue, eggnog, ice cream, and egg-fortified beverages when serving a highly susceptible population.

Facility does not use pasteurized eggs for hot holding scrambled eggs.

Type: Full  
Date: 04/11/23  
Time: 12:00:00  
Report: 1033231056  
Lakeview Senior Housing

# Food and Beverage Establishment Inspection Report

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Comply By: 04/11/23

## 4-500 Equipment Maintenance and Operation

### 4-501.114C3 \*\* Priority 1 \*\*

MN Rule 4626.0805C3 Provide and maintain an approved quaternary ammonium compound sanitizing solution in water with 500 ppm hardness or less, a minimum temperature of 75 degrees F (24 degrees C) and a concentration specified in 21CFR.178.1010 and as indicated by the manufacturer's use directions and label.

Spray bottle in serving kitchen was measured at 0ppm.

Comply By: 04/11/23

## 4-300 Equipment Numbers and Capacities

### 4-302.13B \*\* Priority 2 \*\*

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

Facility does not have a way to measure the internal utensil surface temperature in the dish machine.

Comply By: 04/18/23

## 5-200C Plumbing: Maintenance, fixture location

### 5-205.11AB \*\* Priority 2 \*\*

MN Rule 4626.1110AB The handwashing sink must be accessible at all times for employee use, and must be used only for handwashing.

Employees observed washing dishes in the handsink in the serving kitchen.

Comply By: 04/11/23

---

## Surface and Equipment Sanitizers

Hot Water: = at 160 Degrees Fahrenheit

Location: Dish Machine

Violation Issued: No

---

Quaternary Ammonium: = 0PPM at Degrees Fahrenheit

Location: Spray Bottle

Violation Issued: Yes

---

Quaternary Ammonium: = 400PPM at Degrees Fahrenheit

Location: Kitchen Bucket

Violation Issued: No

---

## Food and Equipment Temperatures

Process/Item: Cold Holding

Temperature: 0> Degrees Fahrenheit - Location: Freezers

Violation Issued: No

---

Type: Full  
Date: 04/11/23  
Time: 12:00:00  
Report: 1033231056  
Lakeview Senior Housing

# Food and Beverage Establishment Inspection Report

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Process/Item: Cold Holding  
Temperature: 34 Degrees Fahrenheit - Location: Cooler  
Violation Issued: No

---

Process/Item: Hot Holding  
Temperature: 164 Degrees Fahrenheit - Location: Meatballs-Warmer  
Violation Issued: No

---

Process/Item: Hot Holding  
Temperature: 187 Degrees Fahrenheit - Location: Baked Potato-Warmer  
Violation Issued: No

---

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

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

I acknowledge receipt of the inspection report number 1033231056 of 04/11/23.

Certified Food Protection Manager Donna Marie Miller

Certification Number: FM86826 Expires: 12/10/25

**Inspection report reviewed with person in charge and emailed.**

Signed: \_\_\_\_\_  
Donna Marie Miller

Signed:  \_\_\_\_\_  
Isaiah Armendariz  
Environmental Health Specialist  
Mankato District Office  
507-344-2743  
isaiah.armendariz@state.mn.us



Report #: 1033231056

# Food Establishment Inspection Report



No. of RF/PHI Categories Out	5	Date	04/11/23
No. of Repeat RF/PHI Categories Out	0	Time In	12:00:00
Legal Authority MN Rules Chapter 4626		Time Out	

Lakeview Senior Housing	Address 651 Us Highway 14 East	City/State Balaton, MN	Zip Code 56115	Telephone 5077346828
License/Permit # 0038443	Permit Holder	Purpose of Inspection Full	Est Type	Risk Category

## FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

## GOOD RETAIL PRACTICES

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

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

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

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

Food Recalls:

Person in Charge (Signature)

Date: 04/13/23

Inspector (Signature)