

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

Telephone: 507-344-2730 Fax: 651-281-9796

HHH

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMPI	
			A. BOILDING.			
		35521	B. WING		04/1	3/2023
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
LAKEVIE	W SENIOR HOUSING	3	GHWAY 14 I I, MN 56115			
(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
0 000	Initial Comments		0 000			
	In accordance with 144G.08 to 144G.9 issued pursuant to Determination of wirequires compliance provided at the Star When Minnesota S failure to comply with considered lack of INITIAL COMMENT SL#35521015 On April 11, 2023, the Minnesota Department of Star Survey at the above correction orders at survey, there were	PROVIDER LICENSING DER(S) Minnesota Statutes, section 5, these correction orders are a survey. hether violations are corrected e with all requirements tute number indicated below. tatute contains several items, th any of the items will be compliance.		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal stag numbers have been assigned Minnesota State Statutes for Assistiving License Providers. The asstag 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 Defic column. This column also include 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 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.	oftware. I to sited signed column Statute xt of the listed in iencies" s the ne state This as eyors' rrection. DING OF TO THIS TO ON FOR TATE	
			0.405	subd. 1, 2, and 3.		
0 430 SS=C	144G.40 Subd. 2 U services	niform checklist disclosure of	0 430			
	(a) All assisted livin	g facilities must provide to				

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

TITLE (X6) DATE

A. BUILDING: COMPLETED 35521 B. WING 04/13/202	
35521 B. WING 04/13/202	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	AME OF PROVIDER OR SUPPLIER
LAKEVIEW SENIOR HOUSING 651 US HIGHWAY 14 EAST BALATON, MN 56115	AKEVIEW SENIOR HOUSIN
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) COMPARISON OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPARISON)	PREFIX (EACH DEFICIENT
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 facilitys (2); a written checklist listing all services permitted under the facility solutions; 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). 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). 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). The findings include: R2 began receiving services under the assisted	prospective reside (1) a disclosure of living licenses avalicense held by the (2) a written check under the facility's the facility offers to living facility control allowed under the provide; and (3) an oral expland under the contract (b) The requirement completed prior to living contract. (c) The commissional interested stake checklist disclosul under paragraph (1) and Amenities (Ulicensee failed to the Uniform Disclosured Amenities (Ulicense). This practice resulting process of the literature of the uniform process of the literature of the uniform process of the literature of the uniform process of the literature of literat

Minnesota Department of Health

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	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		1				
		35521	B. WING		04/1	3/2023
NAME OF F	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
LAKEVIE	W SENIOR HOUSING	i	GHWAY 14 I			
	011111111111111111111111111111111111111		I, MN 56115			
(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
0 430	Continued From pa	ge 2	0 430			
	living license on Au	gust 1, 2022.				
	comprehensive hor 2019, and under the August 1, 2021. R2 and R3's record	y services under the me care license on October 1, e assisted living license on I included a UDALSA stating Facility/Campus listed above				
	has the following lic	cense. Check one: Assisted Dementia Care License."				
		l lacked evidence the correct ed on the UDALSA provided to				
	living director (LALI supervisor (CNS)-B UDALSA failed to of the assisted living facility (ALF). All ressame and identified	at 10:57 a.m. licensed assisted D)-A and clinical nurse B verified R2 and R3's disclose the correct category g license as an assisted living sident contracts were the B the licensee as having an ty with dementia care instead				
	Living Services and August 1, 2021, ind UDALSA will disclose and will list all the s	orm Disclosure of Assisted If Amenities policy dated licated the community se the category of license held ervices and amenities e community's license.				
	No further informati	on provided.				
	TIME PERIOD FOR Twenty-One (21) da					

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		35521	B. WING		04/1	3/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
LAKEVIE	EW SENIOR HOUSING	ì	GHWAY 14 E , MN 56115	EAST		
(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
0 480	Continued From page 3		0 480			
0 480 SS=F	30 144G.41 Subd 1 (13) (i) (B) Minimum		0 480			
	following services to (B) food must be provided to the Minnesota For chapter 4626; and This MN Requirements and the prepared on observation review, the licensed prepared and server Food Code. This practice result violation that did not safety but had the president's health or widespread scope or represent a system or has the potential the residents).	repared and served according bod Code, Minnesota Rules, ent is not met as evidenced on, interview and record a failed to ensure food was ed according to the Minnesota ed in a level two violation (a ot 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				
	and Beverage Esta dated April 11, 2023 Food Code deficier	included document titled, Food blishment Inspection Report 3, for the specific Minnesota acies.				
	(21) days	R CORRECTION: Twenty-one				
0 650 SS=D			0 650			
		t maintain current records of e, each regularly scheduled				

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STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		A. BUILDING.			
	35521	B. WING		04/1	3/2023
NAME OF PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
LAKEVIEW SENIOR HOUSING		GHWAY 14 E , MN 56115	EAST		
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
contractor providing sinclude the following in (1) evidence of current registration, or certific registration, or certific chapter or rules; (2) records of orientation and infection control the evaluations; (3) current job descript qualifications, responsions staff persons providing (4) documentation of a reviews that identify a needed and training in (5) for individuals provided and training in (5) for individuals provided and the dates of those (6) documentation of a required under section. This MN Requirement by: Based on interview are licensee failed to ensure records (clinical nurse included the required. This practice resulted violation that did not he safety but had the pot resident's health or sacause serious injury, in was issued at an isolal limited number of residentice.	ervices, and each individual services. The records must information: Interpretation if licensure, cation if licensure, cation is required by this stion, required annual training training, and competency option, including is ibilities, and identification of an supervision; annual performance areas of improvement needs; viding assisted living that required health ordivision 9 have taken place in escreenings; and in the background study as in 144.057. In the interpretation is not met as evidenced and record review, the supervisor (CNS)-B) content. If in a level two violation (a tharm a resident's health or tential to have harmed a safety, but was not likely to impairment, or death), and ated scope (when one or a sidents are affected or one or taff are involved or the	0 650			

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		35521	B. WING		04/1	3/2023
	PROVIDER OR SUPPLIER	651 US HI	GHWAY 14 I			
		BALATON	I, MN 56115			ı
(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
0 650	Continued From pa	ge 5	0 650			
	The findings include	e:				
		record lacked evidence an ereview was completed.				
		n October 10, 2019, to provide to the licensee's residents.				
	operations (DO)-F	at 1:40 p.m. director of confirmed CNS-B's employee de an annual performance				
	Records policy date indicated the content included documentations.	connel Files Employee ed November 1, 2019, nt of employee records ation of annual performance by areas of improvement and dations.				
	No further informati	on was provided.				
	TIME PERIOD FOR Twenty-One (21) da					
0 790 SS=F	144G.45 Subd. 2 (a physical environme	ı) (2)-(3) Fire protection and nt	0 790			
	(2) install and mair extinguishers in acc Code;	ntain portable fire cordance with the State Fire				
	minimum 2-A:10-B: occupancies, as de located so that the fire extinguisher do	fire extinguishers having a C rating within Group R-3 fined by the State Fire Code, travel distance to the nearest es not exceed 75 feet, and rance with the State Fire				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			B. WING			
		35521			04/1	3/2023
	PROVIDER OR SUPPLIER	651 US HI	DRESS, CITY, S GHWAY 14 I	STATE, ZIP CODE FAST		
LAKEVIE	EW SENIOR HOUSING	i	I, MN 56115			
(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)	D BE	(X5) COMPLETE DATE
0 790	Continued From pa	ge 6	0 790			
	This MN Requirements: Based on observatifialed to verify that visually checked for professional inspect documented annual. This practice result violation that did not safety but had the president's health or cause serious injury was issued at a wide problems are pervatailure that has affer a large portion or a Findings include: On a facility tour on approximately 10:4 Officer (CEO)-E, it extinguishers througannual maintenance 2020, indicating that inspections had not During interview, C	ent is not met as evidenced ion and interview, the licensee each fire extinguisher was ra charge and that a stion/maintenance was ally. ed in a level two violation (and tharm a resident's health or cotential to have harmed a safety, but was not likely to be any, impairment, or death), and despread scope (when asive or represent a systemic coted or has potential to affect and of the residents). April 13, 2023, at 5 a.m. with Chief Executive was observed that the fire ghout the facility, had an e tag with a date of September at annual and monthly to been performed as required. EO-E indicated that the				
	these inspections herecords were requesivere not provided. inspections of the fiby NFPA standards	ased in 2020 and thought and been done. Maintenance ested to verify compliance but Annual and monthly ire extingushers are required and Minnesota State Fire t all systems are maintained ing order.				

Minnesota Department of Health

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		35521	B. WING		04/1	3/2023
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 0-7/1	0/2020
LAKEVIE	EW SENIOR HOUSING	i	GHWAY 14 I			
	OLIMANA DV. OTA		I, MN 56115		ON!	4
(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
0 790	Continued From pa	ge 7	0 790			
	On April 13, 2023, a CEO-E verbally corobservations.	at approximately 12:15 p.m., nfirmed survey staff				
	No further informati	on provided.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
0 800 SS=F		a) (4) Fire protection and nt	0 800			
	walls, floors, ceiling systems, and equip good repair and ope health, safety, comb	cal environment, including I, all furnishings, grounds, Iment in a continuous state of eration with regard to the fort, and well-being of the ance with a maintenance and				
	by: Based on observati failed to provide cur of annual inspection	on and interview, the licensee rrent tags and documentation as of the automatic fire his deficient condition had the taff and residents.				
	violation that did no safety but had the p resident's health or widespread scope (or represent a syste or has the potential residents).	ed in a level two violation (a t 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				
ı	Findings include:					

Minnesota Department of Health STATE FORM

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		35521	B. WING		04/1	3/2023
	PROVIDER OR SUPPLIER	651 US HI	DRESS, CITY, S GHWAY 14 E I, MN 56115	STATE, ZIP CODE EAST		
(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
0 800	Officer (CEO)-E, it is sprinkler riser had a indicating that annuperformed since 20 indicated that the brand thought they had meantime. Mainten to verify compliance Annual inspections system are required Minnesota State Fir systems are maintal order. On April 13, 2023, a LALD-B verbally collaborations. No further informations	April 13, 2023, at 5 a.m. with Chief Executive was observed that the fire an annual maintenance tag al inspections had not been 19. During interview, CEO-E uilding was purchased in 2020 ad inspections in the ance records were requested but were not provided. of the automatic fire sprinkler by NFPA standards and the Code to ensure that all sined and remain in working at approximately 12:15 p.m., infirmed survey staff	0 800			
0 810 SS=F	144G.45 Subd. 2 (bphysical environme) (b) Each assisted Imaintain fire safety plans shall include (1) location and nrooms; (2) employee activa fire or similar emetal (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	0 810			

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		35521	B. WING		04/1	3/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
LAKEVIE	EW SENIOR HOUSING	-	GHWAY 14 E I, MN 56115	EAST		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
0 810	evacuation, or relocemergency including or unusual resident evacuation. (c) Employees of as receive training on plans upon hiring at thereafter. (d) Fire safety and 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 ever the residents is not activation is not readill. This MN Requirements by: Based on a record licensee failed to de evacuation plan with	cation during a fire or similar ag the identification of unique a 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. The capable of assisting in the shall be trained on the lake in the event of a fire to evacuation, or relocation. The lade available to residents at	0 810			
	conduct required expotential to affect a This practice result violation that did no safety but had the p	vacuation, and failed to vacuation drills. This had the ll staff, residents, and visitors. ed in a level two violation (a but harm a resident's health or potential to have harmed a				
	cause serious injur	r safety, but was not likely to y, impairment, or death), and despread scope (when				

Minnesota Department of Health

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winneso	ota Department of He	aith				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		35521	B. WING		04/1	3/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, §	STATE, ZIP CODE	_	
I VKE//IE	EW SENIOR HOUSING	651 US HI	IGHWAY 14 E	EAST		
LANEVIL	W SENIOR HOUSING	BALATON	I, MN 56115	,		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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 APPROL DEFICIENCY)	D BE	(X5) COMPLETE DATE
0 810	Continued From pa	ige 10	0 810			
		asive or represent a systemic ected or has potential to affect II of the residents).				
	Findings include:	I				
	April 13, 2023, at ap Chief Executive Off Assisted Living Dire safety and evacuati	d interview were conducted on pproximately 11:45 a.m. with ficer (CEO)-E and Licensed ector (LALD)-A on the fire ion plan, fire safety and , and evacuation drills for the				
	indicated that the lid actions to be taken emergency. The fact RACE acronym but provide complete ac	ne available documentation censee did not have employee in the event of a fire or similar cility plan indicated to use t was very vague and did not actions for employees to take in or similar emergency.				
	indicated that the lid protection procedur	ne available documentation censee did not have fire res necessary for residents safety and evacuation plan.				
	indicated that the fir did not include proc movement, evacuar or similar emergence of unique or unusuar movement or evacual include some provis residents but did no	ne available documentation re safety and evacuation plan cedures for resident ation, or relocation during a fire cy including the identification al resident needs for uation. The facility plan did sions for relocation of ot specify how to move or or identify the unique and ne residents.				

Minnesota Department of Health STATE FORM

Record review of available documentation

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		35521	B. WING		04/1	3/2023
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
LAKEVIE	EW SENIOR HOUSING		IGHWAY 14 I I, MN 56115			
(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
0 810	indicated that the lie employee training of evacuation plan twi initial hire. Record review of the indicated that the lie training to residents evacuation on the pevent of a fire to incor relocation as required. Record review of the indicated that the lie evacuation drills twe every other month a Provided document drills were not condicated to provide two drills on third shift. During interview, Control the fire safety and explained to provide two drills on third shift.	censee did not provide on the fire safety and ce per year after the training it are available documentation censee did not provide annual who can assist in their own proper actions to take in the clude movement, evacuation, uired by statute. The available documentation censee did not conduct ince per year per shift and as required by statute. The tation indicated that the only lucted every other month and or drills on second shift and two exacuation plan for the facility ions.	0 810			
0 920 SS=C	(c) The contract mu (1) a disclosure of t facility license held is not an assisted li care, a disclosure t assisted living facili	c) Contract information ust include: he category of assisted living by the facility and, if the facility ving facility with dementia hat it does not hold an ty with dementia care license; all the terms and conditions of	0 920			

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35521 B. WING 04/13/20	2023
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
LAKEVIEW SENIOR HOUSING 651 US HIGHWAY 14 EAST BALATON, MN 56115	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CO	(X5) COMPLETE DATE
the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; (3) a delineation of the cost and nature of any other services to be provided for an additional fee; (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; (5) a delineation of the grounds under which the resident's condition of the grounds under which the resident may be transferred or have housing or services terminated or be subject to an emergency relocation; (6) billing and payment procedures and requirements; and (7) disclosure of the facility's ability to provide specialized diets. 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) licenses as required for two of two residents (R2, R3). 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). The findings include: R2 R2's Service Plan Addendum dated March 21,	

Minnesota Department of Health

STATE FORM PW7T11 If continuation sheet 13 of 19

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		35521	B. WING		04/1	3/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
LAKEVIE	EW SENIOR HOUSING		IGHWAY 14 I N, MN 56115			
(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
0 920	Continued From pa	ge 13	0 920			
	bathing, grooming,	vices included assistance with blood glucose monitoring, nitoring and medication				
		g Contract dated August 1, ose the category of the se as an ALF.				
		g Contract dated August 1, ose the category of the se as an ALF.				
	living director (LALI supervisor (CNS)-B contracts failed to d assisted living licen contracts were the s	at 10:57 a.m. licensed assisted D)-A and clinical nurse verified the above resident lisclose the category of the se as an ALF. All resident same and identified the an assisted living facility with ead of an ALF.				
	No further informati	on was provided.				
	TIME PERIOD FOR Twenty-One (21) da					
0 930 SS=C	(d) The contract mu	l-e; 1-4) Contract information ust include a description of the resolution process available to	0 930			

Minnesota Department of Health

STATE FORM PW7T11 If continuation sheet 14 of 19

AND PLAIN OF CORRECTION IDENTIFICATION NOWIDER. A. BUILDING:	
35521 B. WING	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2	ZIP CODE
LAKEVIEW SENIOR HOUSING 651 US HIGHWAY 14 EAST BALATON, MN 56115	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG C	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETE DATE
residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (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; (3) contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an unaffiliated service provider; 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). 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). The findings include: R2	

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Minnesota Department of Health STATE FORM

PW7T11 If continuation sheet 15 of 19

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		35521	B. WING		04/1	3/2023
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	•	
LAKEVIE	EW SENIOR HOUSING		I, MN 56115			
(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
0 930	Continued From pa	ge 15	0 930			
	R2 began receiving living license on Au	services under the assisted gust 1, 2022.				
	signed August 1, 20 description of the fa process available to name and contact in	d an Assisted Living Contract 022. The contract lacked a acility's complaint resolution o residents, including the information of the person cility who is designated to complaints.				
		services under the ne care license on October 1, e assisted living license on				
	signed August 1, 20 description of the fa process available to name and contact in	d an Assisted Living Contract 022. The contract lacked a acility's complaint resolution or residents, including the information of the person cility who is designated to complaints.				
	living director (LALI supervisor (CNS)-B did not include the a	at 1:40 p.m. licensed assisted D)-A and clinical nurse verified R2 and R3's contract above noted required content. residents received the same				
	No further informati	on was provided.				
	TIME PERIOD FOR (21) days	R CORRECTION: Twenty-One				
01060 SS=F	144G.52 Subd. 9 E	mergency relocation	01060			

Minnesota Department of Health

STATE FORM PW7T11 If continuation sheet 16 of 19

MILLIFE	ota Department of He	ailli				
	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		35521	B. WING		04/1	3/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE		
			GHWAY 14 E			
LAKEVII	EW SENIOR HOUSING		I, MN 56115			
(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
01060	Continued From pa	ge 16	01060			
	(a) A facility may refacility in an emerger resident's urgent mrisk the resident po another facility resident possible facility must provide at a minimum: (1) the reason for the facility may service (3) contact information for Los of Ombudsman for Los of Ombudsman for Developmental Disception (4) if known and apor range of dates we expected to return that a return date is (5) a statement that provide housing or resident has the rig 144G.54. The facility information for the facility may submit an apportage (c) The notice required be delivered as soot (1) the resident, leg designated represed (2) for residents who community-based we 256S and section 2 manager; and (3) the Office of Omit the resident has the returned to the facility of the facility of the facility of the resident has the returned to the facility of the facility of the resident has the returned to the facility of the facility of the resident has the returned to the facility of the facility of the facility of the resident has the returned to the facility of the facility o	move a resident from the ency if necessary due to a edical needs or an imminent ses to the health or safety of dent or facility staff member. Cation is not a termination. In emergency relocation, the end a written notice that contains, on the end of the				

Minnesota Department of Health

STATE FORM PW7T11 If continuation sheet 17 of 19

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		SURVEY PLETED
		35521	B. WING		04/	13/2023
	PROVIDER OR SUPPLIER	651 US HI	ORESS, CITY, S GHWAY 14 E I, MN 56115			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
01060	refusal to provide hat termination and trin this section.curred. This MN Requiremed by: Based on interview licensee failed to provide the resident to representative, and an emergency relocation that did not safety but had the president's health or widespread scope for represent a system or has the potential of the residents). The findings include R2's progress notes hospitalized from M21, 2023. R2's records lacked the resident's represent a system of the resident's representative, and an emergency relocation to the residents. The findings include R2's progress notes hospitalized from M21, 2023.	ousing or services constitutes riggers the termination process ently known; and ent is not met as evidenced and record review, the rovide a written notice with the the resident, legal designated representative, for cation for one of two residents ed in a level two violation (and tharm a resident's health or cotential 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 established to affect a large portion or all devidence the resident and sentative had been provided a on as practicable that imum: relocation; tact information for the location on thas been relocated and any er; in for the Office of Ombudsman	01060			

Minnesota Department of Health

STATE FORM PW7T11 If continuation sheet 18 of 19

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		35521	B. WING		04/1	3/2023
	PROVIDER OR SUPPLIER	651 US HI	ORESS, CITY, S GHWAY 14 I I, MN 56115			
(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
01060	expected to return that a return date is -a statement that, if housing or services resident has the rig 144G.54. The facilit information for the amay submit an approximation of the resident or (LALI supervisor (CNS)-B emergency transfer to the resident or the CNS-B stated she of transfer notice if the for four or more day.	to the facility, or a statement on to currently known; and the facility refuses to provide after a relocation, the ht to appeal under section ty must provide contact agency to which the resident eal. at 10:48 a.m. licensed assisted D)-A and clinical nurse a stated there was no notice completed or provided the resident's responsible party. Only completed the emergency to resident was in the hospital tys.	01060			

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Minnesota Department of Health STATE FORM



Type: Full Date: *04/11/23*

Time: 12:00:00 Report: 1033231056

Food and Beverage Establishment Inspection Report

Page 1

Location:

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

License Categories:

Expires on: //

Establishment Info:

ID#: 0038443

Risk:

Announced Inspection: No

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

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 House

Donna Marie Miller

Food and Beverage Establishment Inspection Report

•	33231056 nior Housing		-	_		
	_	ng Fahrenheit - Loc	ation: Cooler			
	_	g s Fahrenheit - Lo	ocation: Meat	balls-Warmer		
	_	g s Fahrenheit - Lo	ocation: Bake	d Potato-Warm	er	
	Total Orders	s In This Report	Priority 1	Priority 2	Priority 3	
NOTE: Plans alterations.	and specification	ns must be submitte	d for review an	d approval prior	to new constructio	n, remodeling or
	I acknowle	dge receipt of the	inspection re	eport number 1	033231056 of 04	11/23.
Certified Fo	od Protection	Manager <u>Donna N</u>	Iarie Miller		_	
Certification	n Number: <u>I</u>	FM86826 J	Expires: <u>12</u>	/10/25		
Inspection	report review	ed with person in	n charge and	emailed.		
Signed:				Signed:	Sund	-

Isaiah Armendariz

Environmental Health Specialist

Mankato District Office

507-344-2743

isaiah.armendariz@state.mn.us

					N	o. of RF/PHI	Categories C	Dut	5	Date	04/11/
					N	o. of Repeat	RF/PHI Cate	gories Out	0	Time In	12:00:
DEPARTMENT OF HEALTH					Le	gal Authori	ty MN Rules (Chapter 4626		Time Ou	ıt
Lakeview Senior Housing	Address		U		y/Stat			Zip Code		phone	
License/Dennit #	651 Us Highway 14 East				laton,		_	56115	507	7346828	
License/Permit # 0038443	Permit Holder			Fu	•	of Inspectio	on 	Est Type		Risk Cate	gory
	DBORNE ILLNESS RISK FAC		RS A	ND P	UBL	IC HEALT					
Circle designated compliance IN= in compliance OUT= not in compliance	status (IN, OUT, N/O, N/A) for each numbered compliance N/O= not observed		I/A – no	ot applic	ablo	60		"X" in appropriate bo site during inspection		S and/or R R= repea	nt violatio
·	N/O= Not observed							-site duffing inspection		K= Tepes	
Compliance Status	Surpervision	cos	K		Com	pliance Sta		nperature Contro	ol for Sa	afetv	С
IN OUT PIC knowledge	eable; duties & oversight			18	IN O	UT N/A N/O		ing time & tempera		arcty	
154	protection manager, duties					-	9	ating procedures for		olding	
	Employee Health							ng time & tempera			
	pwledge,responsibilities&reporting		_	21	O(NI	UT N/A N/O	Proper hot h	olding temperature	es		
() 55.	reporting, restriction & exclusion			22	IN(O	U) N/A	Proper cold I	holding temperatu	ıres		
Procedures for events	responding to vomiting & diarrheal				-	UT N/A N/O		marking & disposi	ition		
i	od Hygenic Practices			24	IN O	UT(N/A) N/O	Time as a pu	ublic health contro	l: proce	dures & reco	rds
	tasting, drinking, or tobacco use		\Box					nsumer Advisory			
	rom eyes, nose, & mouth			25	IN O	UT(N/A)		dvisory provided for		ındercooked	food
	g Contamination by Hands			26	INICO	UT) N/A		usceptible Popul		nde not effe-	nd
B IN OUT N/O Hands clean &	· · ·		\dashv	26	"1(0	0 y 1 v/A		foods used; prohil			_
	contact with RTE foods or pre-approved cedure properly followed			27(IN)O	UT N/A		es: approved & pr			
111	dwashing sinks supplied/accessible			\rightarrow	IN)o			ances properly idea			d
	Approved Source					_	Conformance	e with Approved	Proced	lures	
	from approved source		\dashv	29	IN O	UT(N/A)	Compliance	with variance/spe	cialized	process/HA0	CCP
2 IN OUT N/A N/O Food received	at proper temperature	1	1								
		\vdash									
3 IN OUT Food in good of	condition, safe, & unadulterated										
3 IN OUT Food in good of Required record	rds available; shellstock tags,			D: ·	· fe	(DE)			- (-1. · · ·	find s = 41	
3 IN OUT Food in good of Required recorparasite destru	rds available; shellstock tags, action			Risk	t facto	rs(RF) are in	mproper practi	ices or proceedure	es identi	fied as the m	ost
3 IN OUT Food in good of Required recorparasite destru	rds available; shellstock tags, action n from Contamination			prev	alent o	ontributing fa	actors of foodb	ices or proceedure porne illness or inj t foodborne illness	ury. Pu l	olic Health Ir	ost
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