

Protecting, Maintaining and Improving the Health of All Minnesotans

### **Electronically Delivered**

May 24, 2024

Licensee
Elim Wellspring Assisted Living
104 South 8th Avenue
Princeton, MN 55371

RE: Project Number(s) SL30813015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 1, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

### STATE CORRECTION ORDERS

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

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

#### DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

Elim Wellspring Assisted Living May 24, 2024 Page 2

resident(s)/employed(s) identified in the correction order.

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

### **CORRECTION ORDER RECONSIDERATION PROCESS**

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

To submit a reconsideration request, please visit:

## https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

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

If you have any questions, please contact me.

Sincerely,

Kelly Thorson, Supervisor State Evaluation Team

Email: kelly.thorson@state.mn.us

Telephone: 320-223-7336 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER  ELIM WELLSPRING ASSISTED LIVIN  (X4) ID  SUMMARY STATEMENT OF DEFICIENCIES  STREET ADDRESS, CITY, STATE, ZIP CODE  104 SOUTH 8TH AVENUE  PRINCETON, MN 55371  PROVIDER'S PLAN OF CORRECTION		NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		(X3) DATE S COMPL	
CASIDERION   CONTRICTION   C			30813	B. WING		05/01	1/2024
Initial Comments	NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	•	
PREFIX TAG   (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   (EACH DEFICIENCY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ELIM WE	ELLSPRING ASSISTEI	D LIVIN				
******ATTENTION******  ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)  In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.  Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.  INITIAL COMMENTS:  SL30813015  On April 29, 2024, through May 1, 2024, the Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes of Assisted Living license.  Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes or Assisted Living Indicated Profits and Indicated Statutes of Assisted Living license.  Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes of Assisted Living Indicated Profits and Indicated State Statutes of Assisted Living Indicated Profits and Indicated Indi	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	(X5) COMPLETE DATE
ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)  In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.  Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.  INITIAL COMMENTS:  SL30813015  On April 29, 2024, through May 1, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 32 residents; all receiving services under the provider's Assisted Living license.  documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota Statute Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction.  PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.  THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR	0 000	Initial Comments		0 000			
Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 32 residents; all receiving services under the provider's Assisted Living license.  THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.  THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR		ASSISTED LIVING CORRECTION OR In accordance with 144G.08 to 144G.9 issued pursuant to a Determination of what requires compliance provided at the State When Minnesota Stailure to comply with considered lack of a INITIAL COMMENT	PROVIDER LICENSING DER(S)  Minnesota Statutes, section 5, these correction orders are a survey.  Mether violations are corrected with all requirements tute number indicated below. It tatute contains several items, the any of the items will be compliance.		documenting the State Correction using federal software. Tag number been assigned to Minnesota State Statutes for Assisted Living Facility assigned tag number appears in the far-left column entitled "ID Prefix Tatate Statute number and the corresponding text of the state State of compliance is listed in the "Sum Statement of Deficiencies" column column also includes the findings are in violation of the state requires after the statement, "This Minneson requirement is not met as evidence Following the evaluators in findings."	Orders ers have es. The fag." The mary n. This which ent otal ed by."	
THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL		Minnesota Department of survey at the above correction orders are survey, there were services under the	nent of Health conducted a full provider, and the following re issued. At the time of the 32 residents; all receiving		THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES THE FEDERAL DEFICIENCIES ONLY. WILL APPEAR ON EACH PAGE.  THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION VIOLATIONS OF MINNESOTA STATUTES.  THE LETTER IN THE LEFT COLUMN WHICH STATUTES.	O THIS UMN IS SES AND	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

Minnesota Department of Health

AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION :	COMP	LETED
	30813	B. WING		05/0	1/2024
NAME OF PROVIDER OR SUPPLIE	R STREET AD	DDRESS, CITY,	STATE, ZIP CODE		
ELIM WELLSPRING ASSIST	ED LIVIN	TH 8TH AVE			
CLIMMAN DV C		ON, MN 553		ON	0.45)
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
0 000 Continued From p	age 1	0 000			
			ISSUED PURSUANT TO 144G.35 SUBDIVISION 1-3.	1	
0 680 144G.42 Subd. 10 SS=F emergency prepa	Disaster planning and redness	0 680			
requirements: (1) have a written contains a plan for elements of shelter temporary relocated assignments in the emergency; (2) post an emergency; (2) post an emergency; (3) provide building all residents; (4) post emergency and (5) have a written missing residents (b) The facility must disaster training to orientation and are	emergency disaster plan that revacuation, addresses ering in place, identifies on sites, and details staff e event of a disaster or an ency disaster plan prominently; g emergency exit diagrams to by exit diagrams on each floor; policy and procedure regarding st provide emergency and all staff during the initial staff nually thereafter and must and disaster training annually				
available to all restricted emerger allowed to work oworking on site.	idents. Staff who have not cy and disaster training are nly when trained staff are also st meet any additional				
by: Based on interview licensee failed to preparedness pla	nent is not met as evidenced wand record review, the nave a written emergency (EPP) with all the required the potential to affect all s, and residents.				

Minnesota Department of Health

STATE FORM YR0R11 If continuation sheet 2 of 10

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	COMPI	
		30813	B. WING		05/0	1/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ELIM WE	LLSPRING ASSISTE	D LIVIN	TH 8TH AVENON, MN 553			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
0 680	Continued From pa	ge 2	0 680			
	violation that did not safety but had the president's health or cause serious injury is issued at a wides are pervasive or rep	ed in a level two violation (a t harm a resident's health or otential to have harmed a safety, but was not likely to y, impairment, or death), and opread scope (when problems oresent a systemic failure that the potential to affect a large sidents).				
	The findings include	e:				
		effective date August 2019, on including all the required uarterly review				
	housing (DOH)-A st	at 12:45 p.m. director of ated they review the missing ly, not quarterly and was not ement.				
	date July 13, 2021, 2021, July 1, 2022, elopement drills/rev plan will take place	reviewed/revised October 21, and July 1, 2023, indicated riew of the missing resident on a regular basis, quarterly cific sites and at least s.				
	No further informati	on provided.				
	TIME PERIOD FOR Twenty-One (21) da					
	144G.45 Subd. 2 (a physical environme	) (4) Fire protection and nt	0 800			

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	E CONSTRUCTION	` '	E SURVEY PLETED
		30813	B. WING		05/	01/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
ELIM WE	ELLSPRING ASSISTE	D LIVIN	ΓΗ 8TH AVEN ON, MN 5537			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
0 800	walls, floors, ceiling systems, and equip good repair and ope health, safety, com	ge 3 cal environment, including , all furnishings, grounds, ment in a continuous state of eration with regard to the fort, and well-being of the ance with a maintenance and	0 800			
	by: Based on observation the failed to maintain the environment in a column and operation regard well-being of the reservation.	ent is not met as evidenced on and interview, the licensee he facility's physical ontinuous state of good repair rding the health, safety, and sidents. This had the potential residents, staff, and visitors.				
	violation that did no safety but had the president's health or cause serious injury was issued at a wider problems are pervalaged.	ed in a level two violation (a tharm a resident's health or cotential to have harmed a safety, but was not likely to y, impairment, or death), and lespread scope (when sive or represent a systemic cted or has potential to affect II of the residents).				
	Findings include:					
	with licenses assist and director of house	May 1, 2024, at 1:45 p.m., ed living director (LALD)-C sing (DOH)-A, the surveyor observations of facility air:				
	ceiling in the dining	staining was observed on the room and serving kitchen of leak on the flat roof above				

Minnesota Department of Health

AND PLAN OF CORRECTIO	( , , , , , , , , , , , , , , , , , , ,	VIDER/SUPPLIER/CLIA TIFICATION NUMBER:	` ´	E CONSTRUCTION	COMP	
	30	813	B. WING		05/0	1/2024
NAME OF PROVIDER OR S				STATE, ZIP CODE	1 00/0	1/2024
			H 8TH AVEN			
ELIM WELLSPRING A	SSISTED LIVIN	PRINCET	ON, MN 553	71		
PREFIX (EACH DE		F DEFICIENCIES PRECEDED BY FULL YING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
0 800 Continued F	rom page 4		0 800			
rated doors automatical resident slet the tour LAL resistant ratemake it east room. Fire-rare required installed at the tour throughout the maintain	were disconnectly closing the does in the switch was an and continuated and co	ors as designed on 115 and 113. During resident room fire were disconnected to to enter and exit the pors and hardware ed as designed and truction approval.  humming and not as turned on in the esident room 207.  Derate when tested a lights are required to lly lit while the building				
loss.		of a building power 1, 2024, at 2:05 p.m.,				
LALD-C and observation stated they	DOH-A, verifie	d the above listed anying on the tour and repairs and				
TIME PERIO	DD FOR CORRI	ECTION: Twenty-one				
01370 144G.61 Su SS=D unlicensed	` '	g and evaluation of	01370			
unlicensed (1) docume provided;	personnel must ntation requirem	y evaluations for all include the following: ents for all services resident's condition				

Minnesota Department of Health

STATE FORM YR0R11 If continuation sheet 5 of 10

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	30813	B. WING		05/0	1/2024
NAME OF PROVIDER OR SUPPLIER  ELIM WELLSPRING ASSISTE	D LIVIN	TH 8TH AVEN			
LLIM WLLLOI KING ACCIOTE	PRINCET	ON, MN 5537	<b>'</b> 1		
PREFIX (EACH DEFICIENC)	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
01370 Continued From pa	ge 5	01370			
to the supervisor de (3) basic infection of pathogens; (4) maintenance of environment; (5) appropriate and hygiene and groom (i) hair care and basic (ii) care of teeth, guidevices; (iii) care and use of (iv) dressing and as (6) training on the properties (7) standby assistant perform them; (8) medication, exereminders; (9) basic nutrition, rand assistance with (10) preparation of licensed health properties (11) communication the dignity of the resident and the cultural background (12) awareness of (13) understanding between staff and ramily; (14) procedures to emergency situation (15) awareness of technology equipments.  This MN Requirements of the control of the parameters of the par	esignated by the facility; control, including blood-borne a clean and safe  safe techniques in personal ing, including: thing; ms, and oral prosthetic  thearing aids; and esisting with toileting; mevention of falls; nee techniques and how to reise, and treatment  meal preparation, food safety, meating; modified diets as ordered by a fessional; a skills that include preserving sident and showing respect for exercident's preferences, and family; confidentiality and privacy; appropriate boundaries esidents and the resident's use in handling various and commonly used health cent and assistive devices.  ent is not met as evidenced on, interview, and record efailed to ensure required eted for one of one employee				

Minnesota Department of Health

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	COMPLETED		
		30813	B. WING		05/0	1/2024
	PROVIDER OR SUPPLIER	D LIVIN	DRESS, CITY, S H 8TH AVEN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
01370	Continued From pa	ge 6	01370			
	violation that did no safety but had the president's health or cause serious injury was issued at an ise limited number of realimited number of situation has occurr. The findings include ULP-B began employed direct care provide direct care providing direct care 30, 2024.  ULP-B's employee of the following required.	ed in a level two violation (a tharm a resident's health or obtential to have harmed a safety, but was not likely to y, impairment, or death), and olated scope (when one or a esidents are affected or one or staff are involved or the red only occasionally).  E:  Oyment on August 18, 2021, to services. ULP- was observed a services to residents on April record lacked documentation uired training to be completed				
	-communication ski dignity of the reside	se, and treatment reminders Ils that include preserving the nt and showing respect for the sident's preferences, cultural mily				
	living director (LALE staff on medication, reminders because amenities and serviunder medication medication.	12:50 p.m., licensed assisted D)-C stated they do not train exercise, and treatment in their uniform disclosure of ces document it indicates anagement that they do not of verbal or visual reminders neduled medications.				
	Training Content an Unlicensed Personi	uirements for Instructors, Id Competency Evaluation for Inel-AL policy dated August 9, Ining and competency				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:	(X3) DATE SURVEY COMPLETED
	30813	B. WING	05/01/2024
NAME OF DOOL (DED OD OLIDDI JED	OTDEET AD	DDEGG OITY OTATE ZID GODE	

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

# 404 COUTH OTH AVENUE

ELIM WE	ELIM WELLSPRING ASSISTED LIVIN  104 SOUTH 8TH AVENUE  PRINCETON, MN 55371					
(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		
01370	evaluations for all unlicensed personnel will include the following: -medication, exercise, and treatment reminders -communication skills that include preserving the dignity of client and showing respect for the clients and client's preferences, cultural background, and family  No further information provided.  TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370				
01440 SS=D	· · · · · ·	01440				

Minnesota Department of Health

STATE FORM If continuation sheet 8 of 10 6899 YR0R11

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	` ,	E SURVEY PLETED	
		30813	B. WING		05/	01/2024
	PROVIDER OR SUPPLIER	D LIVIN	DRESS, CITY, S TH 8TH AVEN ON, MN 5537			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
01440	Continued From pa	ge 8	01440			
	Based on observation review, the licensed nurse (RN) conduct performing a delegate providing services of (unlicensed person).  This practice result violation that did not safety but had the person resident's health or cause serious injury was issued at an isolimited number of realimited number of situation has occurrent.	ed in a level two violation (and tharm a resident's health or cotential to have harmed a safety, but was not likely to y, impairment, or death), and colated scope (when one or a esidents are affected or one or staff are involved or the red only occasionally).				
	ULP-E's employee of direct supervision task within 30 days the work was perfor identify problems at relating to the staff's services.  On April 30, 2024, a observed ULP-E peradministration and On May 1, 2024, at	oyment on August 18, 2021. record lacked documentation of performing a delegated of providing services to verify med competently and to nd solutions to address issues a ability to provide the at 7:20 a.m., the surveyor erform medication blood glucose checks.  12:50 p.m. director of housing				
	(DOH)-A stated the supervision for ULF longer than any of t	y do not have a 30-day P-E. ULP-E had been there hem and whoever was in of do it or it is not in her record				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		A. BOILDING.	A. BOILDING.			
	30813	B. WING		05/0	1/2024	
NAME OF PROVIDER OR SUPPL	ER STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
ELIM WELLSPRING ASSIS	TED I IVIN	TH 8TH AVEN				
(VA) ID SLIMMARY	STATEMENT OF DEFICIENCIES	ON, MN 553	PROVIDER'S PLAN OF CORRECT	TION	(X5)	
PREFIX (EACH DEFICIE	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	COMPLETE DATE	
01440 Continued From	page 9	01440				
and was unsure	why.					
The licensee's Sand Licensed Stand Licensed Stand Licensed Standicated supervision delegated task (standicated supervision delegated supervision delegated task (standicated supervision delegated supervision d	upervision of Unlicensed Staff aff-AL policy dated August 2021, ision of ULPs by an RN will be n of the staff performing a ) within 30 calendar days after begins working and first egated resident tasks.  Ination was provided.  OR CORRECTION: Twenty-one					



Minnesota Department of Health Food, Pools & Lodging Services P.O. BOX 64975 ST. PAUL, MN 55164-0975 651-201-4500

Type: Full

Date: 04/29/24
Time: 11:28:00
Report: 1017241076

# Food and Beverage Establishment Inspection Report

Page 1

Location:

Elim Wellspring Assisted Livin

104 South 8th Avenue Princeton, MN55371 Mille Lacs County, 48

Operator:

Risk:

License Categories:

Phone #: 7633890424

Establishment Info:

Announced Inspection: No

ID #: 0037583

ID #:

Expires on: //

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

No NEW orders were issued during this inspection.

## Surface and Equipment Sanitizers

None: = at 162 Degrees Fahrenheit

Location: DISH MACHINE

Violation Issued: No

### Food and Equipment Temperatures

Process/Item: Cold Holding

Temperature: 39 Degrees Fahrenheit - Location: MILK LOCATED IN 2 DOOR COOLER

Violation Issued: No

Process/Item: Hot Holding

Temperature: 190 Degrees Fahrenheit - Location: HAM LOCATED IN STEAM WELL

Violation Issued: No

Process/Item: Hot Holding

Temperature: 190 Degrees Fahrenheit - Location: MASHED POTATOES LOCATED IN STEAM WELL

Violation Issued: No

Process/Item: Hot Holding

Temperature: 192 Degrees Fahrenheit - Location: SPINACH BAKE LOCATED IN STEAM WELL

Violation Issued: No

Process/Item: Hot Holding

Temperature: 188 Degrees Fahrenheit - Location: HAM LOCATED IN STEAM WELL

Violation Issued: No

Page 2

Type: Full
Date: 04/29/24
Time: 11:28:00

# Food and Beverage Establishment Inspection Report

Report: 1017241076

Signed:

Establishment Representative

Elim Wellspring Assisted Livin

	Total Orders In This Report	Priority 1	Priority 2	Priority 3	
		0	0	0	
DISCUSSION	- • •				
	E HAND CONTACT WITH I G, COOLING TIME AND TE		,		
ALL FOOD IS HOME.	S CATERED FROM THE NU	JRSING HON	Æ. DISHES A	RE SANITIZED IN T	HE NURSINO
NOTE: Plans at alterations.	nd specifications must be submitt	ed for review ar	nd approval prior	to new construction, remo	deling or
	I acknowledge receipt of the number 1017241076 of 04/2		Department of H	Iealth inspection report	
Certified Foo	d Protection Manager <u>LAUR</u>	A A DYKERS			
Certification	Number: <u>FM 25868</u>	Expires: 04	/21/25		
Inspection re	eport reviewed with person i	in charge and	l emailed.		

NATE TOPP

PUBLIC HEALTH SANITARIAN ST. CLOUD

320.223.7333

NATE.TOPP@STATE.MN.US

Report #: 10172410	Food Est	abiisnr	me	nt In	spectio	n Repor	τ		
	Minnesota Department of Health					II Categories Ou		0	Date 04/29
	Food, Pools & Lodging Services				No. of Repea	t RF/PHI Catego	ories Out	0	Time In 11:28
DEPARTMENT OF HEALTH	P.O. BOX 64975 ST. PAUL, MN 55164-0975					rity MN Rules Cl			Time Out
Elim Wellspring Assis				City	/State		Zip Code	Tele	phone
	104 South 8th Avenue				ceton, MN		55371	763	3890424
License/Permit # 0037583	Permit Holder			Pur <sub>l</sub> Full	oose of Inspecti	on	Est Type	22	Risk Category
	FOODBORNE ILLNESS RIS	SK FACTO	RS /	AND P	JBLIC HEAL	TH INTERVE	ENTIONS		
Circle design	gnated compliance status (IN, OUT, N/O, N/A) for each	h numbered item	Ì			Mark "X	" in appropriate box	for CO	S and/or R
IN= in compliance	OUT= not in compliance N/O= not obs	erved	N/A=	not applica	ble Co	OS=corrected on-sit	te during inspection	1	R= repeat violat
Compliance St		CC	s R	(	Compliance St	50.0009ec (a 50.00 a) 40.00 m3			
1 (IN) OUT	Surpervision PIC knowledgeable; duties & oversight		-	10 1	NI OLIT NI/A NI/A	Time/Temp Proper cooking	perature Contro		afety
2 (IN)OUT N/A	Certified food protection manager, duties					Proper cooking  Proper reheati			olding
2 111/001	Employee Health		4	l	$\rightarrow$	Proper cooling			olding
3 (IN) OUT	Mgmt/Staff;knowledge,responsibilities&report	ting			$\overline{}$	O Proper hot hol	53		
4 (IN) OUT	Proper use of reporting, restriction & exclusion	n		<b>—</b>	N) OUT N/A	-	olding temperatur		
5 (IN) OUT	Procedures for responding to vomiting & diarr	rheal		23 I	N) OUT N/A N/O	O Proper date m			
	events  Good Hygenic Practices				$\sim$	Time as a pub	A 100 100 100 100 100 100 100 100 100 10		dures & records
6 (IN) OUT N/O		se				Cons	sumer Advisory		
7 (IN) OUT N/O	No discharge from eyes, nose, & mouth			25	N OUT(N/A)	Consumer adv	isory provided fo	or raw/ι	indercooked food
	Preventing Contamination by Hands						sceptible Popul		
8 IN OUT N/C	Hands clean & properly washed			26	N OUT(N/A)		ods used; prohib		
9 (IN) OUT N/A N/C	No bare hand contact with RTE foods or pre- alternate pprocedure properly followed	-approved		27 I	N OUT(N/A)		lor Additives and a proved & pro		
10 IN OUT	Adequate handwashing sinks supplied/acces	ssible			N) OUT		ces properly ider		
	Approved Source	Joinic			1,5001		with Approved		
1 (IN) OUT	Food obtained from approved source			29 I	N OUT(N/A)	-			process/HACCP
	Food received at proper temperature			3 33		1	50.0		
12 IN OUT N/A(N/O	Food received at proper temperature								
	Food in good condition, safe, & unadulterated	d							
13 IN OUT	Food in good condition, safe, & unadulterated Required records available; shellstock tags,	d							
13 IN OUT	Food in good condition, safe, & unadulterated Required records available; shellstock tags, parasite destruction	d				improper practice			
13 IN) OUT  14 IN OUT N/A) N/O	Food in good condition, safe, & unadulterated Required records available; shellstock tags, parasite destruction  Protection from Contamination	d		preva	lent contributing		rne illness or inju	ury. Puk	olic Health Interve
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