Electronically Delivered

October 22, 2024

Licensee
Glenwood Estates
500 Franklin Street North
Glenwood, MN 56334

RE: Project Number(s) SL22169015

Dear Licensee:

On October 10, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the July 25, 2024, survey were corrected. This follow-up survey verified that the facility is back in compliance.

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

Please feel free to call me with any questions.

Sincerely,

Kelly Thorson, Supervisor
State Evaluation Team
Email: kelly.thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

JMD

Electronically Delivered

August 22, 2024

Licensee
Glenwood Estates
500 Franklin Street North
Glenwood, MN 56334

RE: Project Number(s) SL22169015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 25, 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.

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 . . ."

IMPOSITION OF FINES

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

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

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

1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00

2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $6,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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

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

If you have any questions, please contact me.

Sincerely,

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	22169	A. BUILDING: _____ B. WING _____	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENWOOD ESTATES	500 FRANKLIN STREET NORTH GLENWOOD, MN 56334

(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
0 000	Initial Comments ******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: SL22169015-0 On July 22, 2024, through, July 25, 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 21 resident(s); 19 receiving services under the provider's Assisted Living Facility license. An immediate correction order was identified on July 23, 2024, issued for SL22169015-0, tag identification 2310. On July 24, 2022, the immediacy of correction order 2310 was removed, however, non-compliance remained at a level 3, scope of isolated violation (G).	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (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, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated July 23, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 485 SS=C	144G.41 Subdivision 1. (13)(i)(A)and(C) Minimum Requirements	0 485		

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0 485	Continued From page 2 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the Assisted Living contract did not require any resident to include and pay for meals as a part of their assisted living package fee. This had the potential to affect all residents of the facility. 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:	0 485		

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0 485	Continued From page 3 The licensee's contract Attachment C: Meal Plan Addendum dated August 2021 noted: - "Residents can choose to participate in the Community's monthly meal plan, which provides 3 meals per day" and noted the cost of the monthly meal plan was included in the daily rate; and - "Residents can choose to opt out of the Community's monthly meal plan. In that case, no meals would be provided." and noted a monthly rate reduction of $100.00 It also noted under "Meal Plan Participation Selection (please check one)" the following options: - "I would like to participate in the Community's monthly meal plan. I understand this includes 3 meals per day at the rate listed above"; and - "I do not want to participate in the Community's monthly meal plan. I understand that I will not receive any meals through Provider, that a la carte meals are not available at the Community and that I will be responsible for providing all of my own meals which also includes coordination of food delivery and any an all related expenses." On July 25, 2024, at 10:10 a.m., regional manager (RM)-D stated the licensee was aware of this and was in the process of changing the contract to provide options of no meals, one meal, two meals, or three meals per day. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 650 SS=D	144G.42 Subd. 8 Employee records	0 650		

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0 650	Continued From page 4 (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (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 (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee record contained the required content for one of three employees (licensed assisted living director/licensed practical nurse (LALD/LPN))-B. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or	0 650		

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0 650	Continued From page 5 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: LALD/LPN-B had a hire date of July 6, 2020, under the comprehensive home care license and began providing assisted living services on August 1, 2021. LALD/LPN-B's employee record lacked documented evidence of the following: - a current job description to include identification of staff persons providing supervision. On July 24, 2024, at 11:30 a.m., LALD/LPN-B stated her record included an LPN job description, but was unable to locate one for her LALD position. The licensee's Personnel Records policy dated June 13, 2022, noted the employee record would include a signed job description. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 660 SS=E	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity	0 660		

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0 660	Continued From page 6 and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), including documentation of a completed health history and symptom screening for two of three employees (licensed assisted living director/licensed practical nurse (LALD/LPN)-B and unlicensed personnel/ULP-E), and completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for one of three employees (LALD/LPN-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include:	0 660		

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0 660	Continued From page 7 The licensee's TB risk assessment dated July 19, 2024, indicated the licensee was a low risk for TB transmission. LALD/LPN-B LALD/LPN-B had a hire date of July 6, 2020, under the comprehensive home care license and began providing assisted living services on August 1, 2021. LALD/LPN-B's employee record included a two-step TST dated administered on January 5, 2021, and January 18, 2021. However, the tuberculin, lot number C5714AA utilized for both, was noted with an expiration date of June 10, 2020. In addition, LALD/LPN-B's employee record lacked evidence of a health history and symptom screening. ULP-E ULP-E had a hire date of April 8, 2024, to provide assisted living services. ULP-E's employee record contained a Quantiferon-TB Gold blood test dated April 3, 2024. However, it lacked evidence of a health history and symptom screening. On July 24, 2024, at 11:30 a.m., clinical nurse supervisor (CNS)-A stated the expiration date on the tuberculin was before the date administered and should not have been used. In addition, LALD/LPN-B stated her employee record lacked the symptom screening required, and she was not aware the symptom screening needed to be completed with a blood test. The licensee's Tuberculosis & Staff Screening	0 660		

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0 660	Continued From page 8 policy dated June 17, 2022, noted staff who work within the same air space as residents shall be screened and tested for TB prior to being exposed to residents. It noted new personnel would have a two-step TST, and should be screened for active signs of TB using the Baseline TB Screening Tool for Healthcare Workers. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated Baseline TB screening consists of three components: 1. Assessing for current symptoms of active TB disease, 2. Assessing TB history, and 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single IGRA. Also included, an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680		

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0 680	Continued From page 9 (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to practice and document testing of its emergency preparedness plan at least twice annually as required. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 680		

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0 680	Continued From page 10 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During a facility tour with clinical nurse supervisor (CNS)-A on July 22, 2024, at 11:10 a.m., the surveyor observed the facility's layout including one level, with a common sitting room and dining room in the center, and resident apartments on either side down the hallways. The facility's Emergency Preparedness (EP) plan was in a yellow binder, dated as reviewed June 15, 2023. The EP plan lacked evidence the facility had tested its EP plan, conducted and/or participated in a full-scale community-based exercise, or conducted a tabletop exercise to test it's plan and document the results of testing at least twice annually as required. On July 25, 2024, at 9:40 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-B and regional manager (RM)-D stated the plan had been reviewed June 8, 2024, but the binder had not been updated. However, electronic documentation was visualized. LALD/LPN-B stated they had completed a tornado drill on June 15, 2024, including the police, fire department, and sheriff. However, no second drill had been completed as required. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0100, sections A and B, effective October 2022, assisted living facilities shall comply with the federal emergency preparedness	0 680		

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0 680	Continued From page 11 regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans;	0 730		

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0 730	Continued From page 12 (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included all records of communications pertinent to the resident's services for one of two residents (R1). 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	0 730		

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0 730	Continued From page 13 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included chronic obstructive lung disease, movement disorder, and bilateral knee pain. R1's Service Plan dated April 30, 2024, noted services including assistance with bathing, bed mobility, dressing, grooming, and medication administration. R1's record included a fall summary dated March 20, 2024, where R1 was found on the floor. The summary noted a physical therapy (PT) / occupational therapy (OT) referral had been received, and staff were awaiting the initial visit. On July 24, 2024, at 2:40 p.m., clinical nurse supervisor (CNS)-A and licensed assisted living director/licensed practical nurse (LALD/LPN)-B stated R1 had been seen by therapy and discharged. However, no notes were available to indicate what had been done in therapy. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code;	0 790		

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0 790	Continued From page 14 (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 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 23, 2024, from approximately 10:00 a.m. to 11:00 a.m., survey staff toured the facility with maintenance staff (M)-C. The portable fire extinguishers throughout the facility lacked records to show the required monthly visual inspections were complete. Documentation is required to demonstrate fire extinguishers have been inspected by facility personnel monthly. On July 23, 2024, at 11:30 a.m., survey staff explained to M-C that the portable fire	0 790		

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0 790	Continued From page 15 extinguishers must be provided monthly visual inspections or "quick checks" of each extinguisher by their employees to ensure all portable extinguishers are readily available, fully charged, and operable at their designated location with no obvious physical damage or condition to the extinguisher that would prevent their operation when needed. M-C stated they understood the requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in	0 810		

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0 810	Continued From page 16 their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for 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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On June 23, 2024, licensed assisted living director/ licensed practical nurse (LALD/LPN)-B and regional manager (RM)-D provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility.	0 810		

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0 810	Continued From page 17 FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "Fire & Evacuation Plan", dated June 15, 2024, failed to include the following: The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. TRAINING: The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. The licensee's training records, titled "2024 HHA In-service Schedule", dated December 15, 2023, indicated staff were trained on fire safety every April. Staff meeting agenda, titled "April 2024 - EGGS w/ Tracy", dated April 19, 2024, indicated ten (10) staff members attended the meeting. Current staff roster, titled "Glenwood Estates Quick Report - Staff", dated July 22, 2024, indicates there were twenty-one (21) staff members hired prior to April 19, 2024. No other training documentation was provided. On July 23, 2024, at 1:15 p.m., LALD/LPN-B stated they do the training for fire safety upon hire and during the annual table top training every April. LALD/LPN-B stated they were providing all the required training, but was not able to provide documentation that showed all training was completed. LALD/LPN-B and RM-D stated they understood the requirements for training staff on the fire safety and evacuation plan. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		

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0 830	Continued From page 18	0 830		
0 830 SS=D	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for storage of oxygen. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On July 22, 2024, at 12:35 p.m., the surveyor met with R1 in her apartment, and observed four oxygen cylinders on top of a small cabinet next to the wall. R1 stated the tanks are stored there and staff fill the tanks from the compressor on the floor. On July 23, 2024, at 10:00 a.m., clinical nurse supervisor (CNS)-A stated the oxygen was unsecured and he was not aware of the manufacturer recommendations for storage of the	0 830		

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0 830	Continued From page 19 oxygen tanks. On July 24, 2024, at 11:13 a.m., CNS-A provided a delivery note from a medical supply company noting the rental agreement for an oxygen stationary rack that had been ordered. The oxygen cylinder label noted "Secure cylinder during storage and use." Minnesota Department of Health's Oxygen Cylinder Storage Requirements dated April 16, 2020, indicated two types of hazards associated with oxygen are: 1) General fires and explosions enhanced by oxygen-rich atmospheres 2) Mechanical problems such as physical damage to compressed gas cylinder; and noted cylinders must be secured in racks or by chains. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 830		
0 900 SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must:	0 900		

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0 900	Continued From page 20 (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract prior to providing assisted living services for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's Service Plan dated June 18, 2024, noted	0 900		

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0 900	Continued From page 21 services including catheter care, incontinence care, skin sleeves, and transfer assistance. R2's Assisted Living Contract dated December 16, 2021, lacked a signature by the facility and the resident. On July 24, 2024, at 1:05 p.m., regional manager (RM)-D and licensed assisted living director/licensed practical nurse (LALD/LPN)-B stated they would look for the signature page from the contract. However, no further documentation was received. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
01290 SS=H	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced	01290		

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01290	Continued From page 22 by: Based on interview and record review, the licensee failed to ensure all employees with access to residents and resident records had a cleared background study affiliated with the assisted living license in NetStudy 2.0 for 2 of 28 employees (unlicensed personnel/ULP-G, ULP-H). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-G ULP-G was hired on November 24, 2020, to provide direct care services to residents of the facility. ULP-G's employee record contained a background study clearance letter dated September 21, 2021. Review of NetStudy 2.0 noted determination to be "Eligible - Expired" and status reason as COVID-19 study. ULP-H ULP-H was hired on October 12, 2021, to provide direct care services to residents of the facility. ULP-H's employee record contained a background study clearance letter dated October 13, 2021. Review of NetStudy 2.0 noted	01290		

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01290	Continued From page 23 determination to be "Eligible - Expired" and status reason as COVID-19 study. On July 24, 2024, at 11:30 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-B stated she was the sensitive information person (SIP) for the facility, and stated she thought all employees' background studies had been completed with fingerprints as required. Neither of the above employees were observed to be under direct supervision during the survey. The licensee's Background Checks policy dated August 1, 2021, noted a background study on all employees being considered for hire would be completed using the NetStudy program. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC);	01470		

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01470	Continued From page 24 (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual	01470		

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01470	Continued From page 25 and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received orientation to assisted living requirements and regulations prior to providing services for one of three employees (unlicensed personnel/ULP-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-F was a contracted/agency employee and had a hire date of April 8, 2024, to provide assisted living services. ULP-F's employee record contained a Site Orientation for Agency/Temporary Staff sheet which included site tours, electronic record demonstration, and location of the on-call schedule. However, ULP-F's employee record lacked documented evidence of the following required orientation: - an overview of the statutes; - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; - handling of emergencies and use of emergency	01470		

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	22169	A. BUILDING: _____ B. WING _____	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENWOOD ESTATES	500 FRANKLIN STREET NORTH GLENWOOD, MN 56334

(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
01470	Continued From page 26 services; - compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; - consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and - a review of the types of assisted living services the employee will be providing and the facility's category of licensure. On July 24, 2024, at 11:57 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-B stated the agency staff receive this orientation from the staffing agency and not through the licensee, and said they go over the orientation checklist and talk about where to find the policies but do not review the policies, emergency services, complaints, or the provider's scope of license as required. The licensee's Orientation of Personnel & Content policy dated August 1, 2024, noted all personnel providing direct services must complete an orientation to the licensing	01470		

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	22169	A. BUILDING: _____ B. WING _____	07/25/2024

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01470	Continued From page 27 requirements before providing services to residents. It noted the orientation must be completed once for each staff member and was not transferable to another provider, including: - an overview of the appropriate assisted living statutes and rules; - an introduction and review of the facility's policies and procedures related to the provision of services; - handling of emergencies and use of emergency services; - compliance with and reporting of the maltreatment of vulnerable adults; - the assisted living bill of rights; - principles of person-centered planning and service delivery; - handling of residents' complaints, reporting of complaints, and where to report complaints; - consumer advocacy services; and - a review of the types of assisted living services the employee would be providing and the facility's category of licensure. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557;	01500		

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01500	Continued From page 28 (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations,	01500		

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01500	Continued From page 29 isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of three employees (licensed assisted living director/licensed practical nurse (LALD/LPN)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: LALD/LPN-B had a hire date of July 6, 2020, under the comprehensive home care license and began providing assisted living services on August 1, 2021. LALD/LPN-B's employee record lacked documented evidence of the following required annual training: - effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with	01500		

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	22169	A. BUILDING: _____ B. WING _____	07/25/2024

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01500	Continued From page 30 residents who have dementia, Alzheimer's disease, or related disorders. On July 24, 2024, at 11:30 a.m., LALD/LPN-B stated she was unable to locate evidence of this required training. The licensee's Required Annual Training policy dated August 1, 2021, noted annual training must include effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure current written or electronically recorded prescriptions were obtained for one of one resident (R1). 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	01820		

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01820	Continued From page 31 cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on July 22, 2024, at 9:55 a.m., clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to residents at the facility. R1's record lacked an order for prednisone. R1's diagnoses included chronic obstructive lung disease, movement disorder, and bilateral knee pain. R1's Service Plan dated April 30, 2024, noted services including assistance with bathing, bed mobility, dressing, grooming, and medication administration. R1's July 2024 Med (Medication) Admin (Administration) Summary included the following: - prednisone administer one tablet 2.5 milligrams (mg) by mouth every other day. On July 24, 2024, at 2:40 p.m., CNS-A stated the order for prednisone was not available in the resident's chart, and it had just been faxed from pharmacy. The licensee's Medication & Treatment Orders - Renewal policy dated August 1, 2021, noted "Residents who receive medication management services will have a current physician prescribed medication or treatment/therapy orders on record."	01820		

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01820	Continued From page 32 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure mechanical transfer equipment was utilized according to manufacturer directions for one of two residents (R2). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: This practice resulted in an immediate order for correction on July 23, 2024. The surveyor was unable to observe R2 or his bed and transfer devise due to refusal of the	02310		

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	22169	A. BUILDING: _____ B. WING _____	07/25/2024

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02310	Continued From page 33 resident to allow the surveyor to enter his apartment. R2 admitted to the facility on December 16, 2021, with diagnoses including paraplegia, obesity, disruption of perineal wound, and cauda equina syndrome with neurogenic bladder. R2's Service Plan dated June 18, 2024, noted services including assistance with showering, catheter care, dressing, incontinence care, nail care, and assistance with skin sleeves. R2's Resident Notes dated December 16, 2021, noted R2 "uses a mechanical lift for all transfers. He is safely able to operate the lift and place the sling under himself independently. He may need to have one of his legs lifted at times to place the sling under it." R2's Assessment dated June 5, 2024, noted R2 required assistance repositioning his legs in bed, was unable to walk, utilized a catheter and was occasionally incontinent of bowels, has a golden retriever as a service dog, ruptured lumbar discs L2 and nerve damage with no feeling or function to bilateral lower extremities. It noted a pressure ulcer on the left gluteal cleft managed by home care. Under bed safety, it noted the bed to be an adjustable base with a regular mattress, and noted "Resident currently uses gait belt attached to fixed lift to aid in positioning. Has stated that this is more helpful than bed rails." It noted "Resident safely transfers himself with a ceiling lift." In addition, it noted "Resident is at risk for falls as indicated by fall risk assessment score related to age, diagnoses, medications, and history of falls. Resident wears pendant call system around neck, and is able to appropriately use this to call for assistance as needed."	02310		

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02310	Continued From page 34 The Maxi Sky 440 instructions for use dated March 2022, provided by the facility, noted the following: - only parts designated by Arjo should be used on products and other devices supplied by Arjo. Injuries can be caused by the use of inadequate parts; - patient transfers must be done under the supervision of appropriately trained caregivers in accordance with the instructions found in the manual; - lifting capacity of 440 pounds; - device is for transferring only. Do not use for any other reason as it could get damaged and safety of the patient may be compromised; - always ensure the lift was installed by an approved Arjo contractor or installer; - rigorous cleaning actions should be done when exposed to an animal. Pet hair trapped inside the device could reduce the product performance; - "WARNING: All rails must be closed with end stoppers or connected to other closed rail components. Before use, make sure all end stoppers are in place and secured. A wrong installation of these items might lead to a patient fall and to injuries."; - "WARNING: The lift must never be operated by the patient. In the unlikely case of a failure, the patient might get stuck in the unit." - "WARNING: Constant attention to the patient is required from caregiver during the whole transfer. In the unlikely event of a failure of the device, the caregiver must be ready to react." On July 23, 2024, at 10:00 a.m., clinical nurse supervisor (CNS)-A stated R2's lift utilized was not a Hoyer (mechanical) lift or a ceiling lift. CNS-A stated R2 operated the lift independently, and he went to the previous facility to observe	02310		

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02310	Continued From page 35 this, and observes R2 transfer independently with each 90 day reassessment. On July 23, 2024, at 10:15 a.m., CNS-A stated he went into R2's room to get the identification of the lift to provide the manufacturer's recommendations, and R2 stated he did not want the surveyor in his apartment. CNS-A stated R2 refuses to have his weight checked here, and verbally stated his weight would be around 330 pounds. In addition, CNS-A stated R2 places a transfer belt around the lift and uses that to reposition himself in bed, and stated the resident told him the bedrails to no help as much as repositioning himself in this manner. On July 23, 2024, at 1:15 p.m., CNS-A stated the device consisted of two platforms at the base, not attached to the floor. They were approximately four feet long by one foot wide on both sides. Two metal supports came up from the platforms to approximately seven feet tall. The resident's bed was a queen sized bed, and the support was flush against the bed on the left side, and out approximately three feet past the mattress on the right side. Approximately halfway up the support poles is a section that allows to adjust the height, which remains the same. Inside the top section is a track with a lift device that attaches to the sling. R2 puts the sling on himself and staff help with a leg if requested. R2 then lifts himself up with the remote and slides himself to across the bed by grabbing the arm of the wheelchair (which is parked parallel to the bed). He uses the armrest on the wheelchair to slide himself into the wheelchair from the bed. CNS-A stated staff are always present in the room when R2 transfers, but do not assist other than to put the leg up when requested. In regards to turning and repositioning in bed, CNS-A stated R2 has a	02310		

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02310	Continued From page 36 transfer belt that he loops through the buckle onto the support on the side of the lift. This is placed above the blue area midway up on the support where the height can be adjusted and pulled tight. He pulls on the end of the transfer belt to reposition himself. On July 23, 2024, at 1:30 p.m., unlicensed personnel (ULP)-E stated staff are always present in the room when R2 transfers himself with the lift. ULP-E stated R2 will press his pendant when he is ready to get up or go to bed, and staff enter to be in the room with transfers. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE Immediacy is removed as evidenced by supervisor review on July 24, 2024, however noncompliance remains at a scope and level of level three, widespread (l).	02310		

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

Type: Full
Date: *07/23/24*
Time: 15:38:49
Report: 7935241027

Food and Beverage Establishment Inspection Report

Location:
Glenwood Estates
500 Franklin Street North
Glenwood, MN56334
Pope County, 61

Establishment Info:
ID #: 0038662
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3206340022
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.

4-900 Protecting Clean Items

4-903.11A

MN Rule 4626.0955A Store all clean equipment, utensils, linens, single-service and single-use articles in a clean dry location where not exposed to splash, dust, or other contamination and at least six inches above the floor.

THINGS IN DRY STORAGE ROOM STORED ON FLOOR. MOVE UP ON SHELVING.

Comply By: 07/30/24

6-200 Physical Facility Design and Construction

6-202.11A

MN Rule 4626.1375A Provide effective shielding, coated or shatter-resistant light bulbs for all light fixtures where there is exposed food, clean equipment, utensils and linens, or unwrapped single-service or single-use articles.

NEED LIGHT SHIELDS ON LIGHTS IN DRY STORAGE ROOM OR PROVIDE SHATTER PROOF LIGHT BULBS.

Comply By: 07/30/24

6-200 Physical Facility Design and Construction

6-202.15A

MN Rule 4626.1395A Seal holes, gaps, and other openings along floors, walls and ceilings to the outside of the building and provide self-closing, tight-fitting doors and windows for all outside openings.

GAP WITH LIGHT COMING THROUGH VISIBLE ON OUTSIDE DRY STORAGE ROOM DOOR. NEED NEW WEATHER STRIPPING ON DRY STORAGE ROOM DOOR THAT LEADS TO THE OUTSIDE.

Comply By: 07/30/24

Type: Full
Date: *07/23/24*
Time: 15:38:49
Report: 7935241027
Glenwood Estates

Food and Beverage Establishment Inspection Report

Surface and Equipment Sanitizers

Chlorine: = 100 ppm at Degrees Fahrenheit
Location: Sanitizing Bucket
Violation Issued: No

Quaternary Ammonia: = 400 ppm at Degrees Fahrenheit
Location: Spray Bottle
Violation Issued: No

Hot Water: = at 167 Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cooking
Temperature: 201 Degrees Fahrenheit - Location: scrambled eggs
Violation Issued: No

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: upright cooler
Violation Issued: No

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

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

I acknowledge receipt of the MN Department of Health inspection report number 7935241027 of 07/23/24.

Certified Food Protection Manager: Jennifer Crockford

Certification Number: 110284 Expires: 01/19/24

Signed: _____
Establishment Representative

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