



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

September 10, 2026

Licensee

Generations Home Care Inc

2616 1st Street North

Waite Park, MN 56387

RE: Project Number(s) SL33364016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 19, 2026, 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 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>

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.

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,

A handwritten signature in cursive script that reads "Kelly Thorson".

Kelly Thorson, Supervisor

State Evaluation Team

Email: Kelly.Thorson@state.mn.us

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

KKM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33364	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/19/2026
NAME OF PROVIDER OR SUPPLIER GENERATIONS HOME CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2616 1ST STREET NORTH WAITE PARK, MN 56387		
(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: SL33364016-0 On August 17, 2026, through August 19, 2026, 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 six resident(s); six residents receiving services under the Assisted Living Facility license.	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.		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and	0 510			

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

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33364	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/19/2026
NAME OF PROVIDER OR SUPPLIER GENERATIONS HOME CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2616 1ST STREET NORTH WAITE PARK, MN 56387		
(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
0 510	Continued From page 1 maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure services were provided according to accepted health care, medical, or nursing standards in regard to infection control during resident cares for two of three employees (unlicensed personnel (ULP)-C and ULP-D). This had the potential to affect all residents, staff, and visitors at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on August 17, 2026, at 10:12 a.m., licensed assisted living director (LALD)-A stated the licensee provided assistance with ADLs (activities of daily living) to	0 510			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33364	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/19/2026
NAME OF PROVIDER OR SUPPLIER GENERATIONS HOME CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2616 1ST STREET NORTH WAITE PARK, MN 56387		
(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
0 510	Continued From page 2 residents at the facility. ULP-D's Educare (online training platform) Transcript indicated ULP-D completed infection control training on January 29, 2024, February 12, 2025, and December 15, 2025, respectively. On August 17, 2026, at 2:23 p.m., the surveyor observed ULP-D and ULP-F provide scheduled ADLs for R4. ULP-D and ULP-F applied gloves and transferred R4 from R4's wheelchair into bed with assistance from a Hoyer (mechanical) lift. ULP-D applied a second glove layer to ULP-D's right hand and provided peri cares to R4. ULP-D then removed the outer glove layer from ULP-D's right hand and applied barrier ointment to R4. Without performing hand hygiene, ULP-D changed gloves and applied a clean brief, removed trash from R4's room, ULP-F escorted R4 to the dining room and both ULP's removed gloves and completed hand hygiene. On August 18, 2026, at 9:41 a.m., the surveyor observed ULP-C and ULP-D provide scheduled ADLs for R4. ULP-C and ULP-D applied gloves, assisted R4 with range of motion exercises, ULP-C completed peri cares and without changing gloves and performing hand hygiene, ULP-C applied ointment to R4's buttocks. ULP-C then changed ULP-C's right glove without hand hygiene and applied Nystatin (antifungal) powder as prescribed to R4 and completed R4's dressing with ULP-D. ULP-C and ULP-D removed gloves, completed hand hygiene, and ULP-C documented services provided. On August 19, 2026, at 10:42 a.m., ULP-D stated ULP-D was trained to complete hand hygiene before and after cares for each resident, before and after medication passes, and after wearing	0 510			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33364	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/19/2026
NAME OF PROVIDER OR SUPPLIER GENERATIONS HOME CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2616 1ST STREET NORTH WAITE PARK, MN 56387		
(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
0 510	Continued From page 3 gloves. ULP-D stated during cares with R4 ULP-D wore a second glove layer due to personal preference. On August 19, 2026, at 12:37 p.m., licensed practical nurse (LPN)-B stated all employees were trained and expected to complete hand hygiene before and after providing resident cares and completing medication passes, before and after food preparation and serving, and before and after wearing gloves. LPN-B further stated employees were trained to wear gloves during medication passes, resident cares, food preparation, and when cleaning. LPN-B stated employees were trained to change gloves when the gloves were soiled or when moving from a dirty to clean task and it was not acceptable for employees to double-layer gloves. The licensee's Infection Control policy dated August 1, 2021, indicated "[licensee]'s infection control program will be consistent with current guidelines from CDC (Centers for Disease Control) for prevention control in long-term care facilities, where applicable in assisted living facilities." The licensee's Hand Washing and Sanitizing policy dated August 1, 2021, indicated "when conducting a procedure requiring the use of gloves, proper hand hygiene should be completed before donning gloves and after removing gloves." The licensee's Gloves policy dated November 5, 2021, indicated after an employee removed soiled gloves, the employee was expected to wash their hands. No further information was provided.	0 510			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33364	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/19/2026
NAME OF PROVIDER OR SUPPLIER GENERATIONS HOME CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2616 1ST STREET NORTH WAITE PARK, MN 56387		
(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	
0 510	Continued From page 4	0 510			
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of the administration of medications included all required content for one of two residents (R3). 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).	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33364	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/19/2026
NAME OF PROVIDER OR SUPPLIER GENERATIONS HOME CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2616 1ST STREET NORTH WAITE PARK, MN 56387		
(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
01760	Continued From page 5 The findings include: During the entrance conference on August 17, 2026, at 10:12 a.m., licensed assisted living director (LALD)-A stated the licensee provided medication management to residents at the facility. R3's diagnoses included coronary artery disease (narrowing or blockage of the major blood vessels that supply the heart with oxygen-rich blood), hypertension (elevated blood pressure), seizure disorder, depression, and right hemiparesis (muscle weakness or reduced movement control on the right side of the body). R3's [licensee] Service Plan dated March 3, 2026, indicates R3's services included dressing, grooming, bathing, toileting, medication administration three times daily and as needed, meals, standby assistance, transfer assistance, laundry, housekeeping, and safety checks. R3's Yearly Medication Review (prescriber orders) dated March 3, 2026, included an order for Voltaren gel (topical anti-inflammatory pain relief gel), apply every four hours as needed (PRN) for joint pain. R3's [licensee] PRN Medications Tracking Sheet (administration record) dated August 2026 lacked any documentation indicating R3 received application of Voltaren gel. On August 18, 2026, at 8:16 a.m., the surveyor observed unlicensed personnel (ULP)-C apply gloves, assist R3 to transfer from bed to wheelchair and then shower chair. ULP-C then assisted R3 with toileting, peri cares, and	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33364	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/19/2026
NAME OF PROVIDER OR SUPPLIER GENERATIONS HOME CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 2616 1ST STREET NORTH WAITE PARK, MN 56387			
(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
01760	Continued From page 6 showering. On August 18, 2026, and 9:02 a.m., ULP-C stated ULP-C assisted R3 with dressing after R3's shower and applied Voltaren gel to R3's right knee and lower leg. ULP-C further stated the Voltaren gel was applied by staff routinely, every morning and every evening, as requested by R3. On August 18, 2026, at 1:12 p.m., licensed practical nurse (LPN)-B stated employee's who applied R3's Voltaren gel had likely forgotten to document the PRN because at one time it was scheduled medication and employee's may have forgotten to look at the PRN medication record. The licensee's Medication & Treatment Record-Documentation & Refusal policy dated May 30, 2022, indicated [licensee] created and maintained a correct and accurate medication record for each resident receiving medication assistance or administration. The policy further indicated the following must be documented in the resident's medication record after providing medication administration: date, time, quantity or dosage, method of administration, and signature and title of the authorized person who administered the medication. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
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	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33364	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/19/2026
NAME OF PROVIDER OR SUPPLIER GENERATIONS HOME CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 2616 1ST STREET NORTH WAITE PARK, MN 56387			
(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
01820	Continued From page 7 medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prescriber orders contained all required content for one of two residents (R3). This practice resulted in a level two violation (a violation that did not harm a client'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: During the entrance conference on August 17, 2026, at 10:12 a.m., licensed assisted living director (LALD)-A stated the licensee provided medication management to residents at the facility. R3 was admitted to the licensee on May 22, 2018, and began receiving assisted living services on August 1, 2021. R3's diagnoses included coronary artery disease (narrowing or blockage of the major blood vessels that supply the heart with oxygen-rich blood), hypertension (elevated blood pressure), seizure disorder, depression, and right hemiparesis (muscle weakness or reduced movement control on the right side of the body).	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33364	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/19/2026
NAME OF PROVIDER OR SUPPLIER GENERATIONS HOME CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2616 1ST STREET NORTH WAITE PARK, MN 56387		
(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
01820	Continued From page 8 R3's [licensee] Service Plan dated March 3, 2026, indicates R3's services included dressing, grooming, bathing, toileting, medication administration three times daily and as needed, meals, standby assistance, transfer assistance, laundry, housekeeping, and safety checks. R3's Yearly Medication Review (prescriber orders) dated March 3, 2026, included an order for Voltaren gel (topical anti-inflammatory pain relief gel), apply every four hours as needed (PRN) for joint pain. R3's record lacked a prescriber order which included the dose of Voltaren gel to be applied. On August 18, 2026, at 1:14 p.m., licensed practical nurse (LPN)-B stated complete medication orders included the medication name, dose, route, schedule, and specific instructions if needed. LPN-B further stated R4's Voltaren gel order was incomplete, and LPN-B missed it in error. The licensee's Medication & Treatment Orders policy dated August 1, 2021, indicated the RN (registered nurse) was responsible for assuring current, authorized prescriber orders for medications administered were kept in the resident's record. The policy further indicated a medication order included the resident's name, description of the medication, the frequency, duration, and other information needed to carry out the order. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820			



St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301
Phone: 651-201-4500

Food & Beverage Inspection Report

Page: 1

Establishment Info

GENERATIONS HOME CARE INC
2616 1ST STREET NORTH
Waite Park, MN 56387
Stearns County
Parcel:

Phone:
allison.generations@gmail.com

License Info

License: HFID 33364

Risk:
License:
Expires on:
CFPM: HALEY RAE LEASON
CFPM #: 63834; Exp: 1/4/2029

Inspection Info

Report Number: F1037261244
Inspection Type: Full - Single
Date: 8/18/2026 Time: 11:15:09 AM
Duration: minutes
Announced Inspection: Yes
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

DISCUSSED MENU, COOLING, REHEATING, EMPLOYEE ILLNESS RECORDING, BARE HAND CONTACT, DISHWASHING, AND WIPING CLOTHS. ALL HOT FOODS ARE COOKED FOR IMMEDIATE, SAME DAY SERVICE. ALL HIGH RISK ANIMAL FOODS ARE COOKED TO FULLY DONE.

ALLISON TO SEND A PICTURE OF THE TEMPERATURE CHANGING STICKER LEFT ONSITE FOR HOT WATER DISHWASHER FROM NEXT DISHWASHING CYCLE. LAST TEMPERATURE RECORDED FROM ONSITE TEMPERATURE GAUGE WAS 178 DEG F.

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the St Cloud District Office inspection report number F1037261244 from 8/18/2026

ALLISON

Michelle Hovanes,
Public Health Sanitarian 2
320-223-7307
michelle.hovanes@state.mn.us



St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301

Temperature Observations/Recordings

Page: 1

Establishment Info

GENERATIONS HOME CARE INC
Waite Park
County/Group: Stearns County

Inspection Info

Report Number: F1037261244
Inspection Type: Full
Date: 8/18/2026
Time: 11:15:09 AM

Food Temperature: **Product/Item/Unit:** MILK; **Temperature Process:** Cold-Holding

Location: Upright Cooler at 40 Degrees F.

Comment:

Violation Issued?: No

Minnesota (MDH) Version EH Manager; RPT: F1037261244		Food Establishment Inspection Report			Page 1 of 1				
 St Cloud District Office Minnesota Department of Health 4140 Thielman Lane, Suite 101 St Cloud, MN 56301		No. of Risk Factor/Intervention/Violations		0	Date: 8/18/2026				
		No. of Repeat Risk Factor/Intervention/Violations			Time: 11:15:09 AM				
		Score (optional)			Dur: min				
Establishment: GENERATIONS HOME CARE INC		Address: 2616 1ST STREET NORTH		City/State: Waite Park, MN	Zip: 56387	Phone:			
License/Permit #: HFID 33364		Permit Holder:		Purpose of Inspection: Full	Est. Type:	Risk Category:			
FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS									
Designated compliance status (IN, OUT, N/O, N/A) for each numbered item IN=in compliance OUT=not in compliance N/O=not observed N/A=not applicable				Mark "X" in appropriate box for COS and/or R COS=corrected on-site during inspection R=repeat violation					
Compliance Status			COS	R	Compliance Status		COS	R	
Supervision					Time/Temperature Control for Safety				
1	IN	Person in charge present, demonstrate knowledge and performs duties			18	N/O	Proper cooking time & temperatures		
2	IN	Certified Food Protection Manager			19	N/A	Proper reheating procedures for hot holding		
Employee Health					20	N/A	Proper cooling time and temperature		
3	IN	knowledge, responsibilities, and reporting			21	N/A	Proper hot holding temperatures		
4	IN	Proper use of restriction and exclusion			22	IN	Proper cold holding temperatures		
5	IN	Response to vomiting, diarrheal events			23	IN	Proper date marking & disposition		
Good Hygienic Practices					24	N/A	Time as public health control;procedures & record		
6	IN	Proper eating, tasting, drinking, tobacco use			Consumer Advisory				
7	IN	No discharge from eyes, nose, and mouth			25	N/A	Consumer advisory provided for raw or undercooked foods		
Preventing Contamination by Hands					Highly Susceptible Populations				
8	N/O	Hands clean and properly washed			26	IN	Pasteurized foods used; prohibited foods not offered		
9	N/O	No bare hand contact with RTE foods, alternatives			Food/Color Additives and Toxic Substances				
10	IN	Adequate handwashing sinks supplied and access			27	N/A	Food additives; approved & properly used		
Approved Source					28	IN	Toxic substances properly identified;stored;used		
11	IN	Food obtained from approved source			Conformance with Approved Procedures				
12	N/O	Food Received at proper temperature			29	N/A	Compliance with variance, specialized processes & HACCP plan		
13	IN	Food in good condition, safe & unadulterated			Risk factors are improper practices or procedures identified as the most prevalent contributing factors of foodborne illness or injury. Public Health interventions are control measures to prevent foodborne illness or injury				
14	N/A	Records available: shellstock tags, parasite dest.							
Protection From Contamination									
15	IN	Food separated and protected							
16	IN	Food-contact surfaces; cleaned & sanitized							
17	IN	Proper Disposition of returned, previously served, reconditioned,& unsafe food							
GOOD RETAIL PRACTICES									
Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.									
Mark "X" or OUT in box if numbered item is not in compliance Mark "X" in appropriate box for COS and/or R COS=corrected on-site during inspection R=repeat violation									
			COS	R				COS	R
Safe Food and Water					Proper Use of Utensils				
30	N/A	Pasteurized eggs used where required			43		In-use utensils; Properly stored		
31		Water & ice from approved source			44		Utensils, equipment & linens; properly stored, dried, handled		
32	N/A	Variance obtained for specialized processing methods			45		Single-use & single-service articles, properly stored and used		
Food Temperature Control					46		Gloves used properly		
33		Proper cooling methods used; adequate equipment for temperature control			Utensils, Equipment and Vending				
34	N/A	Plant food properly cooked for hot holding			47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
35	N/O	Approved thawing methods used			48		Warewashing facilities: installed, maintained, used; test strips		
36		Thermometers provided & accurate			49		Non-food contact surfaces clean		
Food Identification					Physical Facilities				
37		Food properly labeled; original container			50		Hot & cold water available; adequate pressure		
Prevention of Food Contamination					51		Plumbing installed; proper backflow devices		
38		Insects, rodents, & animals not present; no unauthorized person			52		Sewage & waste water properly disposed		
39		Contamination prevented during food prep, storage, & display			53		Toilet facilities; properly constructed, supplied & cleaned		
40		Personal cleanliness			54		Garbage & refuse properly disposed; facilities maintained		
41		Wiping cloths: properly used & stored			55		Physical facilities installed, maintained & clean		
42		Washing fruits & vegetables			56		Adequate ventilation & lighting; designated areas used		
Person in Charge (signature)				Person in Charge (signature)					
Inspector (signature)				Follow-up: Follow-up Date:					