



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 27, 2023

Licensee
The Farmstead
13733 Quay Street
Andover, MN 55304

RE: Project Number(s) SL20547015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 12, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

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

Please address your cover letter for reconsideration requests to:

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

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

The Farmstead

July 27, 2023

Page 3

If you have any questions, please contact me.

Sincerely,

A handwritten signature in black ink that reads "Kelly Thorson". The signature is written in a cursive, flowing style with a horizontal line above the "T" in Thorson.

Kelly Thorson, Supervisor

State Evaluation Team

Email: kelly.thorson@state.mn.us

Telephone: 320-223-7336 Fax: 651-281-9796

PMB

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20547	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/12/2023
NAME OF PROVIDER OR SUPPLIER THE FARMSTEAD			STREET ADDRESS, CITY, STATE, ZIP CODE 13733 QUAY STREET ANDOVER, MN 55304		
(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: SL20547015 On July 10, 2023, through July 12, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 72 active residents; all receiving services under the Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. 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 subd. 1, 2, and 3.		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480			

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: 20547	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 07/12/2023
NAME OF PROVIDER OR SUPPLIER THE FARMSTEAD			STREET ADDRESS, CITY, STATE, ZIP CODE 13733 QUAY STREET ANDOVER, MN 55304		
(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
0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated July 11, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480			
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and 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	0 510			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20547	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/12/2023
NAME OF PROVIDER OR SUPPLIER THE FARMSTEAD			STREET ADDRESS, CITY, STATE, ZIP CODE 13733 QUAY STREET ANDOVER, MN 55304		
(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 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 establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control related to gloving and hand hygiene, for one of three staff, unlicensed personnel ((ULP)-D). 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 11, 2023, at 7:21 a.m., the surveyor observed ULP-D complete medication administration for R5. ULP-D entered R5's room without hand hygiene performed ULP-D applied gloves and admininstered medications. ULP-D removed gloves and without performing hand hygiene; exited R3's room walked through the hallway, to the elevator to floor one entered through the doors of the nurse station to obtain vitals equipment. ULP-D walked to the elevator to floor three, met R6 and performed "hands on" check back of R6's head. ULP-D entered R6's apartment, placed the vitals equipment on the counter and reached for the phone and keys for	0 510			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20547	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 07/12/2023
NAME OF PROVIDER OR SUPPLIER THE FARMSTEAD			STREET ADDRESS, CITY, STATE, ZIP CODE 13733 QUAY STREET ANDOVER, MN 55304		
(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 the medication cabinet. Without performing hand hygiene, ULP-D applied gloves, and administered medications to R6. ULP-D removed gloves after medication administration and exited R6's apartment without performing hand hygiene. On July 11, 2023, at 8:35 a.m., ULP-D stated they were trained by the registered nurse (RN) to perform hand hygiene with each resident service. ULP-D's Relias training transcript dated May 5, 2023, indicated ULP-D completed a course titled, About Infection Control and Prevention. ULP-D's New Hire RA Skills Competency dated May 9, 2023, indicated a RN signed off completing infection control that included hand hygiene and personal protective equipment. The licensee's undated Infection Control Hand Hygiene policy indicated handwashing shall be performed before and after contact with resident, before donning personal protective equipment and after removing personal protective equipment. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and	0 800			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20547	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/12/2023
NAME OF PROVIDER OR SUPPLIER THE FARMSTEAD			STREET ADDRESS, CITY, STATE, ZIP CODE 13733 QUAY STREET ANDOVER, MN 55304		
(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
0 800	Continued From page 4 repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 11, 2023, approximately from 10:45 a.m. to 1:00 p.m., survey staff toured the facility with the regional environmental service director (RES)-G and the environmental service director (ESD)-F. During the tour, survey staff observed the following: -The emergency lights located in the entry of the memory care unit near room 121 and near room 202 did not light up when tested. -The fire-rated doors for the boiler room (garage level) and the 3rd-floor trash room failed to positively latch when closed. -The fire-rated stairway door (C) discharged onto the courtyard failed to open freely for proper exiting due to the bottom of the door rubbing onto the concrete.	0 800			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20547	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/12/2023
NAME OF PROVIDER OR SUPPLIER THE FARMSTEAD		STREET ADDRESS, CITY, STATE, ZIP CODE 13733 QUAY STREET ANDOVER, MN 55304			
(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
0 800	Continued From page 5 -The two hosebibb connections in the garage level used for maintenance had no backflow preventers installed to prevent cross-connection of the building water supply system. The ESD-F agreed with the finding as he indicated that the hosebibbs were installed after the construction of the building. All listed findings and/or observations were visually and/or verbally verified by the ESD-F and the RESD-G accompanying the tour. On July 11, 2023, at approximately 2:30 p.m., during the exit interview, ESD-F and the RESD-G acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800			
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	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20547	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/12/2023
NAME OF PROVIDER OR SUPPLIER THE FARMSTEAD			STREET ADDRESS, CITY, STATE, ZIP CODE 13733 QUAY STREET ANDOVER, MN 55304		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 810	Continued From page 6 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 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, record review, and interview, the licensee failed to provide the minimum required fire safety and evacuation training for residents who can assist in their evacuation during a fire or similar emergency. This has the potential to directly affect the safety of staff and residents receiving care. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20547	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 07/12/2023
NAME OF PROVIDER OR SUPPLIER THE FARMSTEAD			STREET ADDRESS, CITY, STATE, ZIP CODE 13733 QUAY STREET ANDOVER, MN 55304		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 810	Continued From page 7 On July 11, 2023, approximately from 10:45 a.m. to 1:00 p.m., survey staff toured the facility with the regional environmental service director (RES-D)-G and the environmental service director (ESD)-F. On July 11, 2023, at approximately 1:10 p.m., survey staff received the facility fire safety and evacuation plan and related documentation for review. At approximately 2:00 p.m., document review and interview with the RES-D-G and the ESD-F indicated the licensee lacks annual training for residents who can assist in their own evacuation on the proper actions to take in the event of a fire including movement, evacuation, or relocation as required by statute. Survey staff requested but no documentation was provided or available for review. During the interview, the ESD-F and the RES-D-G verified that the licensee lacked records for the resident annual training on fire safety and evacuation. On July 11, 2023, at approximately 2:30 p.m., during the exit interview, they acknowledged the above finding. Survey staff commented to the RES-D-G that additional information will be honored if received by the end of the day (6/19/2023). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20547	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/12/2023
NAME OF PROVIDER OR SUPPLIER THE FARMSTEAD			STREET ADDRESS, CITY, STATE, ZIP CODE 13733 QUAY STREET ANDOVER, MN 55304		
(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
01620	Continued From page 8 after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure the registered nurse (RN) completed an ongoing reassessment and monitoring on or before day 90 for one of five 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 a limited number of staff are involved or the situation has occurred only occasionally).	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20547	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/12/2023
NAME OF PROVIDER OR SUPPLIER THE FARMSTEAD			STREET ADDRESS, CITY, STATE, ZIP CODE 13733 QUAY STREET ANDOVER, MN 55304		
(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
01620	Continued From page 9 The findings include: On July 10, 2023, at 10:30 a.m., during the entrance conference, clinical nurse supervisor (CNS)-B stated a registered nurse completed assessments pre-admission, within 14 days, every 90 days, and with changes in condition. R1 began receiving services on February 21, 2021. R1's record indicated 90-day comprehensive nursing assessments were completed on August 5, 2022, and November 14, 2022, 101 days apart, and March 14, 2023, 120 days apart, and June 16, 2023, 94 days apart. On July 11, 2023, at 12:10 p.m., registered nurse (RN)-I stated she knew assessments were supposed to be completed within 90 days and is not sure why they were late. On July 11, 2023, at 12:23 p.m., clinical nurse supervisor (CNS)-B stated RN-I is usually really good at keeping track of assessments and further stated the regional nurse also keeps track and alerts them if they have assessments due. On July 11, 2023, at 2:45 p.m., RN-I stated there had been some nursing staff turn around and that may have contributed to assessments not being done on time. The licensee's MN AL Nursing Assessment policy updated May 3, 2022, indicated an RN will complete the comprehensive nursing assessments periodically but no less than every 90-days.	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20547	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/12/2023
NAME OF PROVIDER OR SUPPLIER THE FARMSTEAD		STREET ADDRESS, CITY, STATE, ZIP CODE 13733 QUAY STREET ANDOVER, MN 55304			
(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
01620	Continued From page 10 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620			

Type: Full
Date: 07/11/23
Time: 11:45:52
Report: 1029231163

Food and Beverage Establishment Inspection Report

Page 1

Location:

The Farmstead
13733 Quay Street
Andover, MN55304
Anoka County, 02

Establishment Info:

ID #: 0038865
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7637127000
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.

3-500B Microbial Control: hot and cold holding

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

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

MULTIPLE TCS ITEMS OBSERVED TO BE IN DANGER ZONE AND WERE DISCARDED.

Comply By: 07/11/23

4-600 Cleaning Equipment and Utensils

4-601.11A **** Priority 2 ****

MN Rule 4626.0840A Equipment food-contact surfaces and utensils must be clean to sight and touch.

CAN OPENER ENCRUSTED WITH FOOD DEBRIS. INSTRUCTED OPERATOR TO CLEAN AND MAINTAIN CLEAN.

Comply By: 07/11/23

3-300C Protection from Contamination: equipment/utensils, consumers

3-304.14B

MN Rule 4626.0285B Wiping cloths used for wiping counters and other equipment surfaces must be held in an approved sanitizing solution and laundered daily.

WET TOWELS NOT IN USE HELD IN SOAP WATER. INSTRUCTED OPERATOR TO KEEP IN SANITIZER IF NOT ACTIVELY CLEANING.

Comply By: 07/11/23

Surface and Equipment Sanitizers

Type: Full
Date: 07/11/23
Time: 11:45:52
Report: 1029231163
The Farmstead

Food and Beverage Establishment Inspection Report

Page 2

LACTIC ACID: = ~900 PPM at Degrees Fahrenheit
Location: SPRAY BOTTLE
Violation Issued: No

HOT WATER: = at 162 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: BONE IN SHORT RIBS
Temperature: 145 Degrees Fahrenheit - Location: HOT HOLDING STEAM WELL
Violation Issued: No

Process/Item: CHICKEN KEBABS
Temperature: 149 Degrees Fahrenheit - Location: HOT HOLDING STEAM WELL
Violation Issued: No

Process/Item: SLICED TOMATOES
Temperature: 42 Degrees Fahrenheit - Location: LINE PREP COOLER
Violation Issued: No

Process/Item: SLICED HAM
Temperature: 45 Degrees Fahrenheit - Location: LINE PREP COOLER
Violation Issued: Yes

Process/Item: SLICED TURKEY
Temperature: 46 Degrees Fahrenheit - Location: LINE PREP COOLER
Violation Issued: Yes

Process/Item: PEELED HARD BOILED EGGS
Temperature: 38 Degrees Fahrenheit - Location: LINE PREP COOLER
Violation Issued: No

Process/Item: SLICED CHEESE
Temperature: 47 Degrees Fahrenheit - Location: LINE PREP COOLER
Violation Issued: Yes

Process/Item: CHICKEN CHUNKS
Temperature: 41 Degrees Fahrenheit - Location: LINE PREP COOLER
Violation Issued: No

Process/Item: LIQUID EGG
Temperature: 49 Degrees Fahrenheit - Location: LINE PREP COOLER
Violation Issued: Yes

Process/Item: MILK
Temperature: 48 Degrees Fahrenheit - Location: MEMORY CARE 1ST FLOOR - ON COUNTER
Violation Issued: Yes

Process/Item: 1/2 & 1/2
Temperature: 36 Degrees Fahrenheit - Location: MEMORY CARE 1ST FLOOR - IN COOLER
Violation Issued: No

Type: Full
Date: 07/11/23
Time: 11:45:52
Report: 1029231163
The Farmstead

Food and Beverage Establishment
Inspection Report

Process/Item: MILK Temperature: 44 Degrees Fahrenheit - Location: MEMORY CARE 2ND FLOOR - IN COOLER Violation Issued: Yes
Process/Item: MILK Temperature: 43 Degrees Fahrenheit - Location: MEMORY CARE 2ND FLOOR - IN COOLER Violation Issued: Yes
Process/Item: 1/2 & 1/2 Temperature: 43 Degrees Fahrenheit - Location: MEMORY CARE 2ND FLOOR - IN COOLER Violation Issued: Yes
Process/Item: JUICE Temperature: 39 Degrees Fahrenheit - Location: MEMORY CARE 2ND FLOOR - IN BACK OF COOLER Violation Issued: No
Process/Item: MILK Temperature: 38 Degrees Fahrenheit - Location: SERVER COOLER Violation Issued: No
Process/Item: SOUP Temperature: 193 Degrees Fahrenheit - Location: SERVER AREA HOT HOLDING Violation Issued: No

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

Conducted inspection with Erik Jensen, Nutrition and Culinary Director, and several other staff members. All identified issues were discussed with Erik and staff throughout the inspection. Cold holding issues were identified with the preparation cooler in the main kitchen (which appeared to be a blend of mechanical and behavioral) and with the satellite serving areas (which appeared to be behavioral). The inserts in the preparation cooler were missing in some areas and were allowing cooler air to escape. Staff members in the memory care satellite areas indicated that milk is set out for approximately 20-30 minutes at times for service. Erik and I discussed different procedures for eliminating temperature abuse in the satellite areas, such as taking the milk out for service and pouring it into cups (as is the current practice), but then putting the milk back into the coolers within 5-10 minutes, or in an adequate enough time period so that the milk is not allowed to creep substantially into the danger zone. Erik and I also discussed possible solutions to keeping items out of the danger zone in the preparation cooler. Certain items were discarded, and Erik was instructed to not put additional TCS items into the preparation cooler until safe temperatures were verified.

Topics also discussed with Erik during the inspection included employee illness reporting and exclusion procedures, vomit/fecal matter cleanup, highly susceptible populations, sanitizing, date marking effectively, common contagious foodborne illness pathogens (e.g., salmonella, shigella, Shiga toxin-producing E. coli, hepatitis A virus, and norovirus), hygienic practices (e.g., handwashing), and general food safety practices (e.g., holding temperatures at or below 41°F and 135°F or above for TCS foods).

Type: Full
Date: 07/11/23
Time: 11:45:52
Report: 1029231163
The Farmstead

Food and Beverage Establishment Inspection Report

Page 4

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1029231163 of 07/11/23.

Certified Food Protection Manager Erik Jensen

Certification Number: FM105689 Expires: 01/11/24

Signed: _____

Erik Jensen
Nutrition & Culinary Director

Signed:  _____

Trevor McCliment
Public Health Sanitarian
Metro District Office
651-201-3957
trevor.mccliment@state.mn.us

Report #: 1029231163

DEPARTMENT OF HEALTH

Minnesota Department of Health

Food, Pools, and Lodging Services

625 Robert Street North

St. Paul

No. of RF/PHI Categories Out

2

No. of Repeat RF/PHI Categories Out

0

Legal Authority MN Rules Chapter 4626

Date

07/11/23

Time In

11:45:52

Time Out

The Farmstead

Address

13733 Quay Street

City/State

Andover, MN

Zip Code

55304

Telephone

7637127000

License/Permit #

0038865

Permit Holder

Purpose of Inspection

Full

Est Type

Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item

Mark "X" in appropriate box for COS and/or R

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

Compliance Status

COS

R

Supervision

1

IN

OUT

PIC knowledgeable; duties & oversight

2

IN

OUT

N/A

Certified food protection manager, duties

Employee Health

3

IN

OUT

Mgmt/Staff;knowledge,responsibilities&reporting

4

IN

OUT

Proper use of reporting, restriction & exclusion

5

IN

OUT

Procedures for responding to vomiting & diarrheal events

Good Hygienic Practices

6

IN

OUT

N/O

Proper eating, tasting, drinking, or tobacco use

7

IN

OUT

N/O

No discharge from eyes, nose, & mouth

Preventing Contamination by Hands

8

IN

OUT

N/O

Hands clean & properly washed

9

IN

OUT

N/A

N/O

No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed

10

IN

OUT

Adequate handwashing sinks supplied/accessible

Approved Source

11

IN

OUT

Food obtained from approved source

12

IN

OUT

N/A

N/O

Food received at proper temperature

13

IN

OUT

Food in good condition, safe, & unadulterated

14

IN

OUT

N/A

N/O

Required records available; shellstock tags, parasite destruction

Protection from Contamination

15

IN

OUT

N/A

N/O

Food separated and protected

16

IN

OUT

N/A

Food contact surfaces: cleaned & sanitized

17

IN

OUT

Proper disposition of returned, previously served, reconditioned, & unsafe food

Compliance Status

COS

R

Time/Temperature Control for Safety

18

IN

OUT

N/A

N/O

Proper cooking time & temperature

19

IN

OUT

N/A

N/O

Proper reheating procedures for hot holding

20

IN

OUT

N/A

N/O

Proper cooling time & temperature

21

IN

OUT

N/A

N/O

Proper hot holding temperatures

22

IN

OUT

N/A

Proper cold holding temperatures

23

IN

OUT

N/A

N/O

Proper date marking & disposition

24

IN

OUT

N/A

N/O

Time as a public health control: procedures & records

Consumer Advisory

25

IN

OUT

N/A

Consumer advisory provided for raw/undercooked food

Highly Susceptible Populations

26

IN

OUT

N/A

Pasteurized foods used; prohibited foods not offered

Food and Color Additives and Toxic Substances

27

IN

OUT

N/A

Food additives: approved & properly used

28

IN

OUT

Toxic substances properly identified, stored, & used

Conformance with Approved Procedures

29

IN

OUT

N/A

Compliance with variance/specialized process/HACCP

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

GOOD RETAIL PRACTICES

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

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

COS

R

Safe Food and Water

30

IN

OUT

N/A

Pasteurized eggs used where required

31

Water & ice obtained from an approved source

32

IN

OUT

N/A

Variance obtained for specialized processing methods

Food Temperature Control

33

Proper cooling methods used; adequate equipment for temperature control

34

IN

OUT

N/A

N/O

Plant food properly cooked for hot holding

35

IN

OUT

N/A

N/O

Approved thawing methods used

36

Thermometers provided & accurate

Food Identification

37

Food properly labeled; original container

Prevention of Food Contamination

38

Insects, rodents, & animals not present

39

Contamination prevented during food prep, storage & display

40

Personal cleanliness

41

X

Wiping cloths: properly used & stored

42

Washing fruits & vegetables

COS

R

Proper Use of Utensils

43

In-use utensils: properly stored

44

Utensils, equipment & linens: properly stored, dried, & handled

45

Single-use/single service articles: properly stored & used

46

Gloves used properly

Utensil Equipment and Vending

47

Food & non-food contact surfaces cleanable, properly designed, constructed, & used

48

Warewashing facilities: installed, maintained, & used; test strips

49

Non-food contact surfaces clean

Physical Facilities

50

Hot & cold water available; adequate pressure

51

Plumbing installed; proper backflow devices

52

Sewage & waste water properly disposed

53

Toilet facilities: properly constructed, supplied, & cleaned

54

Garbage & refuse properly disposed; facilities maintained

55

Physical facilities installed, maintained, & clean

56

Adequate ventilation & lighting; designated areas used

57

Compliance with MCIAA

58

Compliance with licensing & plan review

Food Recalls:

Person in Charge (Signature)

Date:

07/13/23

Inspector (Signature)