September 26, 2023

Licensee
Cook Carefree Living, Inc.
151 4th Street Southeast
Cook, MN 55723

RE: Project Number(s) SL27092015

Dear Licensee:

On September 13, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the July 25, 2023, survey were corrected. This follow-up survey verified that the facility is in substantial 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,

Jessie Chenze

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 651-281-9796

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 2, 2023

Licensee
Cook Carefree Living Inc
151 4th Street Southeast
Cook, MN 55723

RE: Project Number(s) SL27092015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 25, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

The correction order documentation should include the following:

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

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

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

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

Please address your cover letter for reconsideration requests to:

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

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

If you have any questions, please contact me.

Sincerely,

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 651-281-9796

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27092	A. BUILDING: _____ B. WING _____	07/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COOK CAREFREE LIVING INC	151 4TH STREET SE COOK, MN 55723

(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: SL#27092015-0 On July 24, 2023, through July 25, 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 14 active residents whom were receiving services under the Assisted Living with Dementia Care 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 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		

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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 had the potential to affect all 14 residents. 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 25, 2023, for the specific Minnesota Food Code deficiencies. On July 31, 2023, a follow up visit was conducted and the priority one (1) deficiency had been corrected. TIME PERIOD FOR CORRECTION: Two (2) days	0 480		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c	0 640		

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0 640	Continued From page 2 The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post required content to include the 911 emergency number in common areas. This had the potential to affect all 14 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) 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 24, 2023, at 2:07 p.m., the surveyor was observing the main areas of the facility with clinical nurse supervisor (CNS)-B. The surveyor did not observe the 911 emergency number posted in the main areas or near two cordless telephones located on a countertop in the main area and a countertop in the secured area.	0 640		

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0 640	Continued From page 3 CNS-B stated the cordless telephones could be used by staff, residents, or visitors. CNS-B stated the 911 emergency number was not posted near the cordless telephones and/or in common areas. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
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 repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. 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) 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).	0 800		

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0 800	Continued From page 4 Findings include: On a facility tour on July 25, 2023, at approximately 11:00 a.m. with maintenance (M)-E the laundry room exhaust fan was missing from the fan housing and not operable. Laundry room exhaust fans are required to be maintained as designed and installed at the time of construction in order to exhaust noxious air from the laundry room. It was also observed that the exhaust vent for the gas water heater in the mechanical/ sprinkler riser room was leaking condensate onto the floor and wall behind the water heater. Water heater exhaust and intake vents are required to be maintained free of leaks in accordance with manufactures installation instructions. On the same tour water damage was observed on the drywall behind the water heater which compromised the fire-resistant rated drywall membrane. The drywall membrane of fire-resistant rated walls is required to be maintained as designed and installed at the time of construction. An exterior emergency light was observed broken and hanging from the electrical wires at the exterior door on the north end of the exit corridor. Emergency light fixtures are required to be maintained as designed and installed at the time of construction. Water damage was observed on the drywall surface around the skylights in the dementia care dining room. Roofs are required to be maintained free of leaks from rain or condensation as designed and installed at the time of construction.	0 800		

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0 800	Continued From page 5 Interior drywall is required to be maintained as installed at the time of construction approval. These deficient conditions were visually verified by M-E accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) 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 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	0 810		

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0 810	Continued From page 6 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 record review and interview, the licensee failed to maintain the facility's fire safety and evacuation plan with required elements. 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) 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). Findings include: A record review of available documentation and interview were conducted on July 25, 2023, at approximately 10:30 a.m. of documents provided by licensed assisted living director (LALD)-A and maintenance (M)-E on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that resident actions required in the event of a fire or similar emergency were not included in the fire safety and evacuation plan. Resident actions required in the event of a fire or similar emergency are required to be included in	0 810		

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0 810	Continued From page 7 the fire safety and evacuation plan. Record review of the available documentation indicated that the licensee did not provided training once per year to residents who are capable of self-evacuation on the proper actions to be taken in the event of a fire regarding movement, evacuation, and relocation. Record review of the available documentation indicated that evacuation drills had been conducted but not in the required sequence of at least once every other month and twice per year per shift. Fire and evacuation drills are required to be documented separately from employee training. All deficiencies were verified by LALD-A and M-E during the interview at approximately 11:00 a.m. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 820 SS=D	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction.	0 820		

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0 820	Continued From page 8 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to affect a limited number of 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 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). Findings include: On a facility tour on July 25, 2023, at approximately 12:00 p.m. with maintenance (M)-E, it was observed an exterior exit gate from the secure outdoor patio area was provided with a push button release fence gate type latch. Gates or doors in the exterior exit path to the public way are required to operate with hardware on the interior of the gate, the same as the building exterior exit doors and release to open in one operation. All clinical staff are required to carry a key to release the latch of the secured gate for egress. This deficient condition was verified by M-E accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) days	0 820		

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01760	Continued From page 9	01760		
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 medications were administered as ordered for one of two residents (R2) who received medication management services. 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 diagnosis included dementia.	01760		

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01760	Continued From page 10 R2's Service Plan, dated June 1, 2023, indicated services to include medication administration. On July 25, 2023, at 7:50 a.m., the surveyor observed unlicensed personnel (ULP)-C administer R2's morning medications following R2's completion of breakfast. R2's prescriber orders dated June 26, 2023, included: amlodipine 10 milligrams (mg) daily (reduce lipid levels), aspirin 81 mg daily (blood thinner), calcium/vit-D 600mg/5 micrograms (mcg) daily (vitamin supplement), furosemide 20 mg daily (diuretic), clopidogrel 75 mg daily (blood thinner), guaifenesin 600 mg twice daily (mucus reducer), loratadine 10 mg daily (treats allergies), losartan potassium 50 mg twice daily (reduce blood pressure), metoprolol 100 mg daily (stabilize heart rate), pantoprazole 40 mg daily (treats reflux), sertraline 50 mg daily (psychotropic to treat Alzheimer's disease), multivitamin daily (vitamin supplement), Metamucil packet daily (prevent constipation), fluticasone nasal spray 50 mcg daily (treats allergies). R2's electronic medical record (EMAR) dated July 2023, instructed loratadine 10 mg tab to be administered daily on an empty stomach per prescriber orders. ULP-C reviewed the EMAR and the bubble pack (foil backed pill organizer) with the surveyor and verified the instructions direct to administer on an empty stomach. ULP-C stated, "all her morning medications are scheduled at the same time (8 a.m.), maybe we need to change that". On July 25, 2023, at 1:24 p.m., clinical nurse supervisor (CNS)-B stated the loratadine medication was scheduled incorrectly based on	01760		

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01760	Continued From page 11 the prescriber directions and the medication time for administration would be changed to accommodate the empty stomach requirement as the prescriber ordered. The licensee's Training Unlicensed Personnel for Medication Administration policy revised January 16, 2023, indicated the registered nurse (RN) would communicate with unlicensed personnel the individual needs of the resident prior to delegation of medication administration to unlicensed personnel. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and	02170		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COOK CAREFREE LIVING INC	151 4TH STREET SE COOK, MN 55723

(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
02170	Continued From page 12 included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop an individualized activity plan for two of two residents (R2, R3) who resided in a secured assisted living with dementia care 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 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: The facility currently held an assisted living with dementia care license.	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27092	A. BUILDING: _____ B. WING _____	07/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COOK CAREFREE LIVING INC	151 4TH STREET SE COOK, MN 55723

(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
02170	Continued From page 13 R2 R2's diagnosis included Alzheimer's disease. R2's assessment dated June 9, 2023, included areas of interest, however, did not evaluate for activity areas, past or current, abilities, skills, emotional social needs, physical abilities or limitations, identification of activities for behavioral interventions, places lived, education, activity preferences, indoor/outdoor and did not include an individualized activity plan for R2. R3 R3's diagnosis included dementia. R3's assessment dated April 12, 2023, included areas of interest, however, did not evaluate for activity areas, past or current, abilities, skills, emotional social needs, physical abilities or limitations, identification of activities for behavioral interventions, places lived, education, activity preferences, indoor/outdoor and did not include an individualized activity plan for R3. On July 25, 2023, at 10:16 a.m., the surveyor reviewed with clinical nurse supervisor (CNS)-B assessments that included the resident interest section. CNS-B stated the electronic system used was not specifically designed to address the individualized activity plan for dementia residents. CNS-B stated she had gathered the provided information and had hoped it met the requirements; however, the licensee did not have an individualized activity plan for R2, R3 or any other residents residing in the secured unit. The licensee's ALDC (assisted living dementia care) Life Enrichment Programs, Activities and Outdoor Space policy dated August 1, 2021,	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27092	A. BUILDING: _____ B. WING _____	07/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COOK CAREFREE LIVING INC	151 4TH STREET SE COOK, MN 55723

(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
02170	Continued From page 14 noted an individualized activity plan would be developed for each resident receiving assisted living services based on their activity evaluation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02170		
02410 SS=D	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by:	02410		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27092	A. BUILDING: _____ B. WING _____	07/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COOK CAREFREE LIVING INC	151 4TH STREET SE COOK, MN 55723

(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
02410	Continued From page 15 Based on observation and interview, the licensee failed to ensure privacy was maintained during medication administration 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 nasal spray medication was administered while R2 was seated in the dining room at a table occupied by co-residents. R2's prescriber orders dated June 26, 2023, included an order for a nasal spray to be administered to both nostrils daily. On July 25, 2023, at 7:45 a.m., the surveyor observed R2 seated at a dining room table in the open dining/living room area. There were two other residents seated at the same table in the dining room eating breakfast. Unlicensed personnel (ULP)-C approached R2 and following appropriate technique administered a nasal spray medication in direct view of the two other residents seated at the dining table. ULP-C did not encourage, offer, or attempt to assist R2 to a private area prior to administering the nasal spray. Directly following the above observation, ULP-C confirmed she had not offered, encouraged, or	02410		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27092	A. BUILDING: _____ B. WING _____	07/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COOK CAREFREE LIVING INC	151 4TH STREET SE COOK, MN 55723

(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
02410	Continued From page 16 provided R2 privacy when administering nasal spray at the dining room table. ULP-C stated, "she just wants it wherever she is at, ya, I suppose it could be a dignity issue". On July 25, 2023, at 1:24 p.m., clinical nurse supervisor (CNS)-B confirmed nasal spray should be administered in private and not in view of other residents. The licensee's Training and Competency of Unlicensed Staff policy revised January 16, 2023, indicated staff would be aware of confidentiality and privacy. A Medication Administration Competency Determination document dated July 2017, indicated staff would offer or provide privacy to residents during medication administration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02410		

Minnesota Department of Health
Food, Pools, & Lodging Services
P. O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *07/25/23*
Time: 10:30:00
Report: 7983231110

Food and Beverage Establishment Inspection Report

Location:
Cook Carefree Living Inc
151 4th Street Se
Cook, MN55723
St. Louis County, 69

Establishment Info:
ID #: 0039394
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2186660200
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.

COLESLAW IN THE BLUE AIR SINGLE-DOOR UPRIGHT REFRIGERATOR WAS 47 F. DISCARD THE COLESLAW, THE COOKED SWEET POTATOES, AND THE PASTA SALADS. LOWER AND MONITOR THE TEMPERATURE OF THE UNIT.

Comply By: 07/25/23

4-200 Equipment Design and Construction

4-203.12 ***** Priority 2 *****

MN Rule 4626.0560 Replace ambient air and water temperature measuring devices that are not accurate to plus or minus 3 degrees F.

THE TEMPERATURE DISPLAY ON THE EXTERIOR OF THE BLUE AIR SINGLE-DOOR UPRIGHT REFRIGERATOR INDICATED A TEMPERATURE OF 30 F. UPON ENTRY INTO THE KITCHEN. FOOD TEMPERATURES RANGED FROM 45-47 F. AIR TEMPERATURE WAS 49 F. CALIBRATE THE DISPLAY.

Comply By: 08/02/23

4-300 Equipment Numbers and Capacities

4-302.14 ***** Priority 2 *****

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

THE SANITIZER TEST STRIPS FOR THE QUATERNARY AMMONIUM SANITIZER EXPIRED 9/15/2021. OBTAIN NEW TEST STRIPS.

Comply By: 08/02/23

Type: Full
Date: *07/25/23*
Time: 10:30:00
Report: 7983231110
Cook Carefree Living Inc

Food and Beverage Establishment Inspection Report

Food and Equipment Temperatures

Process/Item: Walk-In Freezer
Temperature: N/A Degrees Fahrenheit - Location: Food in the walk-in freezer was frozen solid.
Violation Issued: No

Process/Item: Walk-In Refrigerator
Temperature: 39 Degrees Fahrenheit - Location: Sliced cheese.
Violation Issued: No

Process/Item: Upright Refrigerator
Temperature: 45 Degrees Fahrenheit - Location: Raw shell egg in the Blue Air single-door upright refrigerator.
Violation Issued: No

Process/Item: Upright Refrigerator
Temperature: 47 Degrees Fahrenheit - Location: Coleslaw in the Blue Air single-door upright refrigerator.

Violation Issued: Yes

Process/Item: Refrigerator/Freezer
Temperature: 37 Degrees Fahrenheit - Location: Milk in the refrigerator compartment of the GE refrigerator/freezer in the AL kitchenette.
Violation Issued: No

Process/Item: Refrigerator/Freezer
Temperature: 41 Degrees Fahrenheit - Location: Milk in the refrigerator compartmentof the GE refrigerator/freezer in the MC kitchenette.
Violation Issued: No

Process/Item: Warewashing Machine
Temperature: 150 Degrees Fahrenheit - Location: Wash water temperature.
Violation Issued: No

Process/Item: Warewashing Machine
Temperature: 194 Degrees Fahrenheit - Location: Rinse water temperature.
Violation Issued: No

Process/Item: Warewashing Machine
Temperature: 160 Degrees Fahrenheit - Location: Utensil surface temperature.
Violation Issued: No

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

==========

GENERAL COMMENTS:

1) Discussed excluding food employees ill with vomiting or diarrhea, eliminating bare hand contact with ready-to-eat food, and ensuring that in-house inspections of daily operations are conducted on a periodic basis to ensure that food safety policies and procedures are followed.

2) Provided an illness reporting fact sheet, an employee illness decision guide, an employee illness log, a vomit cleanup poster, a TCS food fact sheet, a temperature/time fact sheet, and a cooling fact sheet.

3) A follow-up inspection regarding food temperatures in the Blue Air single-door upright refrigerator will be conducted.

==========

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 7983231110 of 07/25/23.

Certified Food Protection Manager: Andrea Simonson

Certification Number: Pending Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed: _____

Andrea Simonson
Person in Charge

Signed: 7983

651-201-4500
health.foodlodging@state.mn.us

Minnesota Department of Health
Food, Pools, & Lodging Services
P. O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Follow-Up
Date: *07/31/23*
Time: 14:30:00
Report: 7983231115

Food and Beverage Establishment Inspection Report

Location:
Cook Carefree Living Inc
151 4th Street Se
Cook, MN55723
St. Louis County, 69

Establishment Info:
ID #: 0039394
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2186660200
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 previously issued on 07/25/23 have NOT been corrected.

4-200 Equipment Design and Construction

4-203.12 ***** Priority 2 *****

MN Rule 4626.0560 Replace ambient air and water temperature measuring devices that are not accurate to plus or minus 3 degrees F.

SEE GENERAL COMMENT 2 BELOW.

Issued on: 07/25/23 *Comply By: 08/02/23*

4-300 Equipment Numbers and Capacities

4-302.14 ***** Priority 2 *****

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

THE SANITIZER TEST STRIPS FOR THE QUATERNARY AMMONIUM SANITIZER EXPIRED 9/15/2021. OBTAIN NEW TEST STRIPS.

Issued on: 07/25/23 *Comply By: 08/02/23*

No NEW orders were issued during this inspection.

Food and Equipment Temperatures

Process/Item: Upright Refrigerator
Temperature: 37 Degrees Fahrenheit - Location: Raw shell egg in the Blueair single-door upright refrigerator.

Violation Issued: No

Type: Follow-Up
Date: *07/31/23*
Time: 14:30:00
Report: 7983231115
Cook Carefree Living Inc

Food and Beverage Establishment Inspection Report

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

==========

GENERAL COMMENTS:

1) Follow-up inspection re. food temperature in the Blueair single-door upright refrigerator. Raw shell eggs were 37 F. This order has been corrected.

2) 7/25/2023: The temperature display on the exterior of the Blueair single door upright refrigerator indicated a temperature of 30 F. upon entry into the kitchen. Food temperatures ranged 45 - 47 F. Air temperature was 49 F.

7/31/2023: The temperature display indicated a temperature of 27 F. Eggs inside were 37 F.

Place an accurate thermometer inside of the unit until the display is calibrated.

==========

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 7983231115 of 07/31/23.

Certified Food Protection Manager: Andrea Simonson

Certification Number: Pending Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed: _____

Adalei Dunn
Person in Charge

Signed: 7983

651-201-4500
health.foodlodging@state.mn.us