Electronically Delivered

November 30, 2023

Licensee
Willow House LLC
25611 110th Street Northwest
Zimmerman, MN 55398

RE: Project Number(s) SL34968015

Dear Licensee:

On November 21, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the October 4, 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, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

HHH

Electronically Delivered

October 18, 2023

Licensee
Willow House LLC
25611 110th Street Northwest
Zimmerman, MN 55398

RE: Project Number(s) SL34968015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 4, 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.

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 . . ."

IMPOSITION OF FINES

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

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

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5), the MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
The MDH may impose a fine of $1,000 for each substantiated maltreatment violation that consists of

abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The MDH also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

St - 0 - 0820 - 144g.45 Subd. 2 (g) - Fire Protection And Physical Environment - $3,000.00
St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00

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

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

The correction order documentation should include the following:

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

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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the MDH within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

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

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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34968	A. BUILDING: _____ B. WING _____	10/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW HOUSE LLC	25611 110TH STREET NW ZIMMERMAN, MN 55398

(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: SL34968015 On October 2, 2023, through October 4, 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 five (5) active residents; all of whom were receiving services under the Assisted Living license. Immediate correction orders were identified on October 2 and 3, 2023, issued for SL34968015, tag identification 0820 and 1290 respectively. On October 3, 2023, at 2:02 p.m., the immediacy of correction order 1290 was removed, however, non-compliance remained at a scope and level of I. On October 9, 2023, the immediacy of correction order 0820 was removed, however non-compliance remained at a scope and level of	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.	

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0 000	Continued From page 1 I.	0 000		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the required staffing plan was posted in a central location as required. This had the potential to affect all	0 470		

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0 470	Continued From page 2 residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 2, 2023, at 11:21 a.m., the surveyor observed the common areas shared by residents, staff, and visitors lacked the required posting of a daily staffing schedule. Licensed practical nurse (LPN)-C stated the licensee did not have a daily staffing schedule posted. On October 2, 2023, at 1:45 p.m., clinical nurse supervisor (CNS)-B stated the licensee failed to post a daily staff schedule as required. The licensee's Staffing policy dated August 1, 2021, indicated a daily staffing schedule is prepared by the CNS and is posted at the beginning of the shift in a central location in each building, if applicable, accessible to staff, residents, volunteers, and the public. Minnesota Rules - Assisted Living Facilities 4659.0180 Staffing, subpart (4) (B) indicates a daily work schedule must be posted, after redacting direct-care staff members' resident assignments, at the beginning of each work shift in a central location in each building of a facility or campus, accessible to staff, residents, volunteers, and the public.	0 470		

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0 470	Continued From page 3 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 October 2, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 650 SS=F	144G.42 Subd. 8 Employee records	0 650		

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0 650	Continued From page 4 (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records contained the required content for two of two employees (unlicensed personnel (ULP)-G, clinical nurse supervisor (CNS)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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	0 650		

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0 650	Continued From page 5 of the residents). The findings include: During the entrance conference on October 2, 2023, at 12:46 p.m., CNS-B stated the licensee was aware of the required contents of employee records. COMPTENCY TRAINING AND TESTING ULP-G was hired on June 19, 2019, and had begun providing assisted living services on August 1, 2021. On October 2, 2023, at 6:04 a.m., ULP-G stated training and competency testing was done by a previous registered nurse (RN) and CNS-B. On October 2, 2023, at 9:49 a.m., the surveyor observed ULP-G put on R1's left orthotic brace (AFO). ULP-G's record lacked training and a competency evaluation for an AFO. On October 2, 2023, at 2:50 p.m., CNS-B stated CNS-B completed a training and competency evaluation for R1's left AFO for all ULPs, however, was unable to locate the training and competency evaluations for all ULPs. ANNUAL PERFORMANCE REVIEWS ULP-G ULP-G was hired on June 19, 2019, and had begun providing assisted living services on August 1, 2021. On October 3, 2023, at 10:24 a.m., the surveyor observed ULP-G complete a blood glucose reading for R1.	0 650		

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0 650	Continued From page 6 ULP-G's employee record contained an annual performance review dated June 18, 2021, however, lacked an annual performance review for 2022 and 2023. CNS-B CNS-B was hired on February 20, 2017, and had begun providing assisted living services on August 1, 2021. CNS-B's employee record contained an annual performance review dated May 6, 2022, however, lacked an annual performance review for 2023. On October 2, 2023, at 2:17 p.m., CNS-B stated CNS-B and ULP-G's employee records lacked annual performance reviews and annual reviews should be completed every year on the employee's anniversary hire date. The licensee's Personnel Records policy dated August 1, 2021, indicated at minimum, personnel records would include performance reviews and competency evaluations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies	0 680		

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0 680	Continued From page 7 temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents, staff, and visitors of 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), 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:	0 680		

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0 680	Continued From page 8 During the entrance conference on October 2, 2023, at 10:53 a.m., the surveyor asked for the licensee's EPP, which was provided and later reviewed by the surveyor. The licensee's EPP dated August 1, 2021, included a binder with generic instructions for staff to follow in the case of a fire, snow and cold, utility disruption, unsafe home situation, external emergency, pandemic, civil unrest, shelter in place, and severe weather. The licensee's EPP provided did not include the following: - annual review of the EPP; - a quarterly review of the missing resident policy; - a description of the population served by the licensee; - development of policies/procedures to address: - procedure for tracking staff and residents; - subsistence needs for staff and residents during an emergency to include (food, water, medical supplies, pharmacy supplies, sewer and waste disposal, emergency lighting, fire detection, extinguishing and alarm systems; - evacuation plan which included staff responsibilities during an evacuation and transporting services for residents being evacuated; - emergency staffing strategies to include volunteers; - development of arrangements with other facilities and providers to receive residents if needed; and - the facilities role in providing care and treatment at alternative sites under a 1135 waiver; - arrangement with other facilities with signed memorandums of agreement; - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy; and	0 680		

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0 680	Continued From page 9 - a method of sharing information from the EPP with residents and their families. On October 3, 2023, at 9:23 a.m., clinical nurse supervisor (CNS)-B stated the licensee's EPP did not address the following information as noted above, the EPP was not reviewed annually, and the licensee was unaware the missing resident plan needed to be reviewed quarterly. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated the licensee will have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. The licensee's Missing Resident policy dated August 1, 2021, indicated the missing resident procedure will be reviewed by the director and CNS at least quarterly. Per Assisted Living Facilities: Minnesota Rules Chapter 4659, 4659.0110, Subp. 4. Review missing resident plan. The assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter	0 780		

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0 780	Continued From page 10 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that are interconnected throughout the facility so that actuation of one alarm will cause all alarms in the dwelling to actuate. This deficient condition had the ability to affect all staff and 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, 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	0 780		

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WILLOW HOUSE LLC	25611 110TH STREET NW ZIMMERMAN, MN 55398

(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
0 780	Continued From page 11 failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a facility tour on October 2, 2023, between approximately 12:14 p.m. with Maintenance (M-A), survey staff observed that smoke alarms throughout the facility were not interconnected so that actuation of one alarm will cause all alarms in the dwelling to actuate. This was discovered when the M-A tested the smoke alarms intercom. M-A verbally confirmed survey staff observations during the facility tour. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee	0 790		

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0 790	Continued From page 12 failed to maintain fire extinguishers in accordance with MN State Fire Code. This deficient condition had the ability to affect all staff and 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, 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). Findings include: On a facility tour on October 2, 2023, at approximately 11:06 a.m. to 1:30 p.m., with Licensed Practical Nurse (LPN-C), survey staff observed that the fire extinguishers throughout the facility, did not have any current tags or documentation to indicate that annual and monthly inspections had been performed as required. The annual inspection tag was from 2022 and monthly documentation had been done in 2022 but nothing was documented for 2023. Annual and monthly inspections of the fire extingushers are required to show that they are being maintained in accordance with MN State Fire Code. LPN-C verbally confirmed survey staff observations. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790		

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0 800	Continued From page 13	0 800		
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 designate an approprate means of egress from the facility. 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 the potential to affect a large portion or all of the residents). The findings include: On October 2, 2023, from approximately 11:06 a.m. to 1:30 p.m., survey staff toured the facility with Licensed Practical Nurse (LPN-C). During the facility tour, survey staff observed that an exit sign was posted above the door leading from the house to the garage. The means of egress is required to lead and exit directly to a yard or court from occupied spaces within the facility or through a room of equal or less hazard which excludes the garage. This exit door was included	0 800		

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0 800	Continued From page 14 in this facilities fire safety evacuation plan. LPN-C verbally confirmed survey staff observations. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) 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.	0 810		

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0 810	Continued From page 15 (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 a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements, failed to provide required employee and resident training on fire safety and evacuation, and failed to conduct required evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 and interview were conducted on October 2, 2023, at approximately 11:45 a.m. with Certified Nurse Supervisor (CNS-B) 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 the evacuation plan did not include complete procedures for residents' evacuation, or	0 810		

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0 810	Continued From page 16 relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. The current plan shows procedures for residents movement but does not get into the evacuation and relocation process. Record review of the available documentation indicated that the licensee did not provide training for employees on the fire safety and evacuation plans upon hire and at least twice per year thereafter. Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month for employees as required by statute. Documentation showed evacuation drills being done in 2021 and 2022 but nothing for 2023. During interview, CNS-B verified that the fire safety and evacuation plan for the facility lacked these provisions. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 820 SS=I	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	0 820		

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0 820	Continued From page 17 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. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide properly sized egress windows for resident rooms that did not create a distinct hazard for residents. This had the potential to directly affect a portion of the residents and staff. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).The findings include: On October 02, 2023, approximately from 11:51 a.m. to 1:30 p.m., survey staff toured the facility with the Licensed Practical Nurse (LPN-C). At approximately 1:14 p.m., survey staff asked LPN-C to open the window in occupied resident bedroom #1 on the main floor for measurement. LPN-C opened the window, and the survey staff measured the clear opening to be 19 inches in width and 49.5 inches in height with a total openable area of 940.5 square inches. The windows do not meet the minimum requirements for opening width.	0 820	This immediate correction order identified on October 2, 2023, has had the immediacy lifted as of October 9, 2023 by assigning a fire watch for the facility. This was confirmed by the licensee via email and approved by evaluation supervisor. Facility also stated that they had adjusted the hardware on all the non-compliant windows to come into compliance.	

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0 820	Continued From page 18 At approximately 1:23 p.m., survey staff asked LPN-C to open the window in occupied resident bedroom #2 on the main floor for measurement. LPN-C opened the window and survey staff measured the clear opening to be 16 inches in width and 49.5 inches in height with a total openable area of 792 square inches. The windows do not meet the minimum requirements for opening width. At approximately 1:30 p.m., survey staff asked LPN-C to open the window in occupied resident bedroom #3 on the main floor for measurement. LPN-C opened the window and survey staff measured the clear opening to be 19.5 inches in width and 41.5 inches in height with a total openable area of 809.25 square inches. The windows do not meet the minimum requirements for opening width. Survey staff explained to LPN-C that at least one egress window in each bedroom must be provided to meet the minimum state standard for an egress window to be a complying bedroom for resident occupancy. LPN-C verbally confirmed the findings. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. On October 02, 2023, at approximately 1:35 p.m., at the exit interview, survey staff explained to Clinical Nurse Supervisor (CNS-B) that an immediate correction order was issued for the above finding. CNS-B acknowledged the above finding.	0 820		

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0 820	Continued From page 19 No Further information was provided. TIME PERIOD FOR CORRECTION: Immediate.	0 820		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure current employee records contained all the required content to include a background study clearance letter for seven of thirteen employees (unlicensed personnel (ULP)-G, ULP-D, ULP-E, ULP-I, ULP-J, ULP-K, and maintenance (M)-A). This had the potential to affect all residents living within the facility. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to	01290		

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01290	Continued From page 20 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: This resulted in an immediate correction order on October 3, 2023, at approximately 12:10 p.m. ULP-G ULP-G was hired on June 19, 2019, and had begun providing assisted living services on August 1, 2021. On October 3, 2023, at 10:24 a.m., the surveyor observed ULP-G complete a blood glucose reading for R1. ULP-D ULP-D was hired on May 20, 2019, and had begun providing assisted living services on August 1, 2021. ULP-E ULP-E was hired on November 18, 2020, and had begun providing assisted living services on August 1, 2021. ULP-I ULP-I was hired on September 9, 2021, and had begun providing assisted living services on August 1, 2021. ULP-J ULP-J was hired on May 6, 2021, and had begun providing assisted living services on August 1, 2021.	01290		

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01290	Continued From page 21 ULP-K ULP-K was hired on September 12, 2019, and had begun providing assisted living services on August 1, 2021. M-A M-A was hired on October 13, 2022, and had begun providing maintenance services under the assisted living license on August 1, 2021. ULP-G, ULP-D, ULP-E, ULP-I, ULP-J, ULP-K, and M-A's employee records lacked documentation of a cleared background study. On October 3, 2023, from 11:02 a.m., through 11:12 a.m., clinical nurse supervisor (CNS)-B stated the above employees were currently working and was not able to verify a cleared background study on Net Study 2.0. CNS-B stated the above employee background studies were previously ran under the facilities comprehensive license in Net Study 2.0, however, the licensee could no longer access the comprehensive account as the account was disabled. CNS-B further stated the licensee would have no way of being notified if any above employees background checks were to come back as ineligible. The licensee's Recruitment and Hiring policy dated, August 1, 2021, indicated the employment process would include a criminal background check submitted to the Minnesota Department of Human Services, would be maintained in the employee file, and if satisfactory results the hiring process would continue. The licensee's Personnel Records policy dated August 1, 2021, indicated all personnel records at	01290		

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01290	Continued From page 22 minimum would include results of background studies. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate Immediacy is removed as confirmed by surveyor supervisor on October 3, 2023, at 2:02 p.m., however, non-compliance remains at a scope and level of three, widespread (I).	01290		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel,	01790		

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01790	Continued From page 23 including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one unlicensed personnel ((ULP)-G) was trained and had demonstrated competency to prepare and	01790		

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01790	Continued From page 24 give medications for residents having unplanned time away. 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: During the entrance conference on October 2, 2023, at 12:42 p.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services. ULP-G was hired on June 19, 2019, and had begun providing assisted living services on August 1, 2021, which included medication administration. On October 3, 2023, at 7:51 a.m., the surveyor observed ULP-G provided scheduled morning medication administration for R2. ULP-G's employee record lacked evidence to indicate ULP-G had been trained and demonstrated competency to provide medications to residents for unplanned times away from home. On October 3, at 2:26 p.m., CNS-B stated ULP-G had not been trained or deemed competent to prepare and give medications to residents for an unplanned time away. CNS-B stated no ULP at the facility had been trained or deemed competent to prepare and give medications to	01790		

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01790	Continued From page 25 residents for an unplanned time away. The licensee's Medication Management Plan for Residents Away from Home policy dated August 1, 2021, indicated the registered nurse (RN) may delegate to a ULP to provide the medications based on the following: -the RN has trained the home health aide (ULP) and determined the home health aide competency [sic] to follow procedures for giving medications to residents; -the RN has instructed the home health aide to ensure that all appropriate precautions are taken; and - the RN has developed written procedures/protocols for the home health aide, including special instructions regarding controlled substances. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01790		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were secure and permitted only authorized personnel access for one of one medication refrigerator. In addition, the licensee failed to	01880		

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	34968	A. BUILDING: _____ B. WING _____	10/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW HOUSE LLC	25611 110TH STREET NW ZIMMERMAN, MN 55398

(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
01880	Continued From page 26 secure one of two residents (R2) opened insulin pens. This had the potential to 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 the potential to affect a large portion or all the residents). The findings include: During the entrance conference on October 2, 2023, at 12:42 p.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services. MEDICATION REFRIGERATOR On October 2, 2023, at 4:14 p.m., the surveyor reviewed the medication refrigerator with licensed practical nurse (LPN)-C located in the community living and dining room. LPN-C stated the medication refrigerator was unlocked when the surveyor opened the refrigerator door. The medication refrigerator contained the following medications: -one (1) unopened Emgality 120 milligrams (mg)/milliliter (mL); -four (4) unopened Novolog 100 units/mL pens for R2; and -six (6) unopened Lantus 100 units/mL pens for R2. On October 2, 2023, at 4:17 p.m., LPN-C stated the medication refrigerator should be always locked.	01880		

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01880	Continued From page 27 INSULIN PENS On October 3, 2023, at 7:51 a.m., the surveyor observed unlicensed personnel (ULP)-G provide scheduled morning medication administration for R2, including insulin pen administration. Immediately following the observation, the surveyor observed R2 place R2's two (2) insulin pens in the upper unlocked cabinet at the staff desk located in the dining room. At 7:58 a.m., ULP-G stated that R2's open insulin pens were always stored in the upper unlocked cabinet, and anyone could have access to the insulin pens. On October 3, 2023, at 8:56 a.m., CNS-B stated all resident medications should be stored in a locked closet or a locked medication refrigerator, and only staff who completed medication administration should have access to the medications. The licensee's Storage/Control of Medications policy dated August 1, 2021, indicated medications are stored in a secured medication cabinet/closet. Only authorized nursing personnel have access to the locked cabinet/closet. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription	01890		

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01890	Continued From page 28 label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to monitor for expired medications in one of one medication closet storing the licensee's stock medications. 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). The findings include: During the entrance conference on October 2, 2023, at 12:42 p.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services. On October 2, 2023, at 4:02 p.m., the surveyor reviewed the locked medication closet in the kitchen with licensed practical nurse (LPN)-C and confirmed the following licensee's stock medications were expired: -approximately 3/4 bottle of alcohol 70 percent (%) expired July 2023; -full bottle of peroxide expired December 2021; -approximately ¾ bottle of aloe gel sunburn with lidocaine relief expired June 2023; -approximately ¾ bottle of pain reliver 500 milligram (mg) tablets expired July 2023; -full tube of hydrocortisone antiitch 1% expired	01890		

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01890	Continued From page 29 February 2022; - full tube of Icy Hot cream expired July 2023; and -full bottle of Robitussin cough and chest congestion expired September 2023. On October 2, 2023, at 4:09 p.m., LPN-C stated staff should be checking for expired medications one time per month. On October 3, 2023, at 8:55 a.m., CNS-B stated nurses would typically be going through each medication bin every month and checking for expiration dates. In addition, staff should be checking for expiration dates prior to administering medications. The licensee's Storage/Control of Medications policy dated August 1, 2021, indicated a licensed nurse will regularly set up medications in a clearly labeled container based on the resident's medication regimen. At that time, the nurse checks medication expiration dates and notes any medications needing to be reordered. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be	01970		

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01970	Continued From page 30 renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure written or electronically recorded orders were maintained for one of one resident (R1) who received treatments managed by the provider. 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). The findings include: During the entrance conference on October 2, 2023, at 12:45 p.m., clinical nurse supervisor (CNS)-B stated the licensee provided treatment services to residents. R1's diagnoses included cerebral infarction (stroke), diabetes, chronic low back pain, and recurrent depressive disorder. R1's Service Plan dated January 10, 2023, indicated R1 required assistance with medication administration, blood glucose checks, housekeeping, and assistance with bathing, grooming, dressing, and toileting. On October 3, 2023, at 10:24 a.m., the surveyor observed unlicensed personnel (ULP)-G complete a blood glucose reading for R1.	01970		

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01970	Continued From page 31 R1's prescriber orders dated June 7, 2023, indicated to check R1's blood glucose daily. R1's record lacked a clarification order to increase blood glucose checks to four (4) times per day. On October 4, 2023, at 9:41 a.m., CNS-B stated R1's blood glucose checks order should have been clarified to increase blood glucose checks to four (4) times per day when R1 began taking insulin four (4) times per day. The licensee's Treatment and Therapy Management policy dated August 1, 2021, indicated the registered nurse (RN) or licensed health professional will obtain orders or prescriptions for all treatments and therapies. The order will include the following elements: -resident name; -description of the treatment or therapy provided; -frequency; and -other pertinent information. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced	02310		

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02310	Continued From page 32 by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for one of one resident (R1) with a hospital bedrail. 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 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: R1's diagnoses included cerebral infarction (stroke), diabetes, chronic low back pain, and recurrent depressive disorder. On October 3, 2023, at 9:49 a.m., the surveyor observed R1 lying in bed. R1's bed had bilateral upper bedrails with the right upper bed rail in the upper position and the left upper bed rail in the lowered position. R1's Service Plan dated January 10, 2023, indicated R1 required assistance with medication administration, blood glucose checks, housekeeping, and assistance with bathing, grooming, dressing, and toileting. R1's Bed Safety Assessment dated July 17, 2023, indicated R1 had bilateral quarter side (bed) rails attached to the hospital bed. R1 used the bed rails to assist with mobility due to left sided paralysis. The bed rails appeared securely and	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34968	A. BUILDING: _____ B. WING _____	10/04/2023

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02310	Continued From page 33 tightly affixed to the bed. The bed rails did not function as a restraint. R1 was not at risk for injury due to cognition, no previous injury related to bed rails, was not taking any medications that would affect R1's mental status, and risks and benefits of the bedrails were discussed, and understanding was verbalized by R1. In addition, the following was documented: -Zone 1: The area within the rail was less than 4 ¾ inches; -Zone 2: The area under the rail, between the rail supports or next to a single rail support was less than 4 ¾ inches; -Zone 3: The area between the rail and mattress was less than 4 ¾ inches; -Zone 4: The area under the rail, at the ends of the rail was less than 2 3/8 inches and greater than a 60-degree angle at the end of the bed rail relative to the top; -Zone 5: The space between the split bed rails did not present a risk of head, neck, or chest entrapment; Zone 6: The gap between the end of the bed rail and the side edge of the headboard did not present a risk of entrapment of the head, neck, or chest; and Zone 7: There was no large space between the inside surface of the headboard and the end of the mattress that could cause risk of head entrapment. R1's record lacked a comprehensive assessment on the use of an assistive device to include actual measurements of the entrapment zones. On October 4, 2023, at 9:43 a.m., clinical nurse supervisor (CNS)-B stated R1's bed rails were assessed at least every 90 days. CNS-B further stated CNS-B had physically inspected the bed rails and completed measurements on each bed	02310		

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02310	Continued From page 34 rail zone, however, did not document the actual measurement on the bed rail assessment. The licensee's Side Rail Use policy dated August 1, 2021, indicated the registered nurse (RN) would conduct a side (bed) rail assessment, ensure that the side (bed) rails in use are of a safe design and properly maintained, and the need for side (bed) rails would be reassessed and documented as needed at least every 90 days. The FDA "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) dated August 7, 2023, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Measurements; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and	02310		

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02310	Continued From page 35 - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

DEPARTMENT OF HEALTH

Type: Full
Date: *10/02/23*
Time: 10:55:18
Report: 1037231253

Food and Beverage Establishment Inspection Report

Location:
Willow House Llc
25611 110th Street Nw
Zimmerman, MN55398
Sherburne County, 71

Establishment Info:
ID #: 0038287
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7636076874
ID #:

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

The following orders were issued during this inspection.

4-700 Sanitizing Equipment and Utensils

4-703.11B ***** Priority 1 *****

MN Rule 4626.0905B Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.

MAINTAIN A LOG OF THE HOT WATER DISHWASHER TEMPERATURE REACHING A MINIMUM OF 160 DEG F AT THE UTENSIL / PLATE LEVEL.

Comply By: 11/02/23

4-200 Equipment Design and Construction

4-201.11AMN

MN Rule 4626.0506A Provide or replace food service equipment with equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

REMOVE AIR FRYER FROM THE KITCHEN. REPLACE WITH ANSI APPROVED COOKING EQUIPMENT IF NEEDED.

Comply By: 10/16/23

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

DISHWASHER WAS NOT FUNCTIONING AT THE TIME OF INSPECTION. REPAIR OR REPLACE.

Comply By: 11/02/23

Type: Full
Date: *10/02/23*
Time: 10:55:18
Report: 1037231253
Willow House Llc

Food and Beverage Establishment Inspection Report

Surface and Equipment Sanitizers

Quaternary Ammonia: = 400 at Degrees Fahrenheit
Location: TEMPORARY 3RD COMPARTMENT SINK
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 36 Degrees Fahrenheit - Location: PRECOOKED RICE
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 41 Degrees Fahrenheit - Location: MILK JUG
Violation Issued: No

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

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

I acknowledge receipt of the inspection report number 1037231253 of 10/02/23.

Certified Food Protection Manager: MELISSA KOOP

Certification Number: 118896 Expires: 09/15/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: Michelle L Hovanes

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