Electronically Delivered

April 28, 2025

Licensee
Brainerd Carefree Living LLC
2723 Oak Street
Brainerd, MN 56401

RE: Project Number(s) SL20187016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 3, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20187	A. BUILDING: _____ B. WING _____	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRAINERD CAREFREE LIVING LLC	2723 OAK STREET BRAINERD, MN 56401

(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 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: SL20187016-0 On March 31, 2025, through April 3, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 53 residents; 53 receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480		

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated March 31, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer	0 480		

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0 480	Continued From page 3 to the FBEIR for any compliance dates.	0 480		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program to comply with accepted health care, medical, and nursing standards for infection control for one of three employees (unlicensed personnel/ULP-E). 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:	0 510		

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0 510	Continued From page 4 On March 31, 2025, at 3:50 p.m., the surveyor observed ULP-E perform a blood glucose check for R6 at the table in the common area by the medication cart on third floor. ULP-E placed gloves on her hands, placed the test strip in the glucometer, wiped R6's left middle finger with an alcohol wipe, poked the finger with a lancet, wiped the finger, and placed blood on the test strip. After completing the task, ULP-E placed the lancet in her gloved left hand with the alcohol wipe and wrapper, removed the glove, and placed it in the trash. ULP-E then performed hand hygiene and placed the supplies back in the medication cart. At this time, ULP-E stated she should have placed the lancet in the sharps container, not the trash. On April 1, 2025, at 10:34 a.m., clinical nurse supervisor (CNS)-A stated staff are to place the lancet in the sharps container, not the trash. The licensee's Blood Glucose Monitoring policy dated April 4, 2025, noted "Immediately dispose the contaminated lancet into the sharp's container. Use caution to avoid a needle stick injury when disposing if not a self-contained safety lancet." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 650 SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The	0 650		

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0 650	Continued From page 5 records must include the following infomation: (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 the employee record contained the required content for one of three employees (unlicensed personnel/ULP-E). 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:	0 650		

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0 650	Continued From page 6 ULP-E was an agency staff working at the facility to provide direct care services to residents. On March 31, 2025, at 3:50 p.m., the surveyor observed ULP-E perform a blood glucose check for R6. ULP-E's employee record lacked documented evidence of the following required orientation: - a review of the provider's policies and procedures; - handling emergencies and using emergency services; - reporting maltreatment of vulnerable adults; - handling of resident complaints, reporting of complaints, and where to report; and - a review of the types of Assisted Living services the employee would provide and the provider's scope of license. On April 3, 2025, at 10:12 a.m., clinical nurse supervisor (CNS)-A stated she spends about an hour and a half with agency staff when they come doing training and competency testing, and going over the emergency binder. CNS-A stated the above required content was covered, but was not documented in ULP-E's employee record. The licensee's Employee Record Requirements policy dated November 12, 2024, noted the employee record would include records of orientation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		

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0 730	Continued From page 7	0 730		
0 730 SS=E	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received	0 730		

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0 730	Continued From page 8 and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included a discharge summary with the required content for one of one discharged resident (R4). In addition, the licensee failed to document resolutions to complaints received for three of eleven complaints received. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: DISCHARGE RECORD R4's record included a Discharge Summary dated December 31, 2024, which noted R4 received assistance with activities of daily living, medication administration, and showers. However, it lacked a summary of the resident's stay that included:	0 730		

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0 730	Continued From page 9 - diagnoses; - course of illnesses; and - allergies. R4 admitted to the facility on January 23, 2024, and discharged on December 31, 2024. R4's diagnoses included type 2 diabetes mellitus and peripheral vascular disease. R4's Service Plan dated January 23, 2024, indicated R4 received services including assistance with bathing, dressing, and medication administration. On April 3, 2025, at 10:17 a.m., clinical nurse supervisor (CNS)-A stated the above required content was not included on R4's discharge summary. The licensee's Resident Discharge policy dated April 4, 2025, noted the registered nurse would complete a discharge summary including diagnoses, courses of illnesses, and allergies. COMPLAINTS The licensee provided eleven Complaint Concern Forms submitted by residents. The complaints dated January 7, 2025, (two complaint forms) and January 9, 2025, included notes including the findings and action taken by a former employee. However, the written notes were illegible. On April 3, 2025, at 10:10 a.m., assisted living director in residency (ALDIR)-B stated he was unable to read the writing to say what had been completed. No further information was provided.	0 730		

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0 730	Continued From page 10 TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days	0 730		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to comply with the requirements of Minnesota State Fire Code Rules, Chapter 7511. 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 April 3, 2025, at 9:40 a.m., the surveyor toured the facility with maintenance (M)-F. During the facility tour, the surveyor observed the following: CARBON MONOXIDE ALARMS Carbon monoxide alarms were not installed in resident rooms or corridors. During the facility tour interview, M-F stated there was fuel-fired equipment in the building and a carbon monoxide	0 775		

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0 775	Continued From page 11 detector was installed in the foyer. M-F stated no additional carbon monoxide detectors or alarms were installed in the building. When carbon monoxide alarms are not tied into the building fire alarm system, carbon monoxide alarms are required to be installed within ten feet of all sleeping rooms. Carbon monoxide alarm and detection systems in existing buildings are required to be installed in accordance with MSFC in Minnesota Rules Chapter 7511. CONTROLLED EGRESS DOOR LOCKING SYSTEM - Electromagnetic locks were installed on emergency exit doors. A signal or switch was not installed that had the capability of unlocking the controlled egress locking system. During the facility tour interview, M-F verified the above listed observation. The entire egress control locking system shall have the capability of being unlocked by a signal or switch from the fire command center, a nursing station, or other approved location. The signal or switch shall directly break power to the locks. Egress control locking systems must comply with Minnesota State Fire Code Rules, Chapter 7511 for the entire locking system. - On April 3, 2025, assisted living director in residence (ALDIR)-B and M-F provided emergency plan procedures. Record review indicated the emergency plan did not include procedures to operate and unlock the electromagnetic controlled locking door system. During an interview on April 3, 2025, at 1:40 p.m., ALDIR-B verified this information was not included in the plan. SMOKING MATERIAL DISPOSAL Burnt cigarettes had been disposed of on the ground and inside a garbage can containing	0 775		

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0 775	Continued From page 12 combustible materials in the gazebo. During the facility tour interview, M-F verified smoking materials had been improperly disposed. FIRE DOOR MAINTENANCE - The labeled 90-minute fire door for the second floor stairwell was propped open with a wedge. - Several fire-resistant rated resident room doors throughout the facility were held open with wedges or magnetic door catches in order to prevent the door from automatically closing. The devices used to hold open these fire-resistant rated doors were not tied to the building fire alarm system in order to release the doors to close automatically in the event of fire alarm activation. During the tour interview, M-C verified the above listed fire door observations. Fire-resistant rated doors are required to be maintained as designed and installed to automatically close and latch. The doors are required to automatically close and latch to protect the path of egress in the corridor in the event of a fire or similar emergency in accordance with MSFC in Minnesota Rules Chapter 7511. SMOKE ALARM MAINTENANCE M-C removed the smoke alarm from the ceiling bracket in resident room 106. The date on the back of this smoke alarm was 2009. Smoke alarms shall be replaced when they exceed 10 years from the date of manufacture. During the tour interview, M-C verified the above listed observation and stated this smoke alarm must have been missed when the other smoke alarms were replaced. OBSTRUCTED EGRESS A rack of clothing and a 3 drawer storage unit were stored in the corridor outside of the laundry	0 775		

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0 775	Continued From page 13 room on the first floor. This storage was in the exit path leading from the corridor to the emergency exit on the east side of the building. During the tour interview, M-C verified the above listed observation. Marked exit paths are required to be maintained clear of obstructions that prevent immediate and full use of the exit path in the event of a fire or similar emergency. LIFE SAFETY SYSTEMS MAINTENANCE - The fire alarm system annual service tag was dated October 2023 indicating the fire alarm system had not been inspected and tested in the past year. - The service tag was dated March 2024 for the kitchen ventilation hood automatic fire suppression system. M-C provided an inspection and maintenance report dated March 29, 2024, for the automatic fire suppression system indicating the extinguishing system had not been inspected and serviced at least every six months. During the tour interview, M-C verified the above listed observations. Fire alarm systems and automatic fire suppression systems shall be inspected and maintained by qualified individuals in accordance with MSFC in Minnesota Rules Chapter 7511. - One fire sprinkler was hanging down several inches below the ceiling in the dining room. During the tour interview, M-C verified the above listed observation and stated one of the brackets may have broken. Sprinklers must be maintained to ensure proper activation in the event of a fire. EXTENSION CORD USE An extension cord was used to supply power in occupied resident room 307, creating a fire hazard. During the tour interview, M-C verified the extension cord observation.	0 775		

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0 775	Continued From page 14 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 775		
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 failed to maintain the portable fire extinguishers as required by statute. This deficient condition 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 of the residents). The findings include: On April 3, 2025, at 9:40 a.m., the surveyor	0 790		

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0 790	Continued From page 15 toured the facility with maintenance (M)-F. During the facility tour, the surveyor observed the tags attached to the portable fire extinguishers were dated March 2024, indicating annual maintenance had not been performed by certified service personnel in the past year. During the facility tour interview, M-F verified the above listed observations. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff 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) Staff 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	0 810		

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0 810	Continued From page 16 least once per year. (f) Evacuation drills are required for staff 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 develop the fire safety and evacuation plan with required content, make the plan readily available, and provide required training. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: On April 3, 2025, maintenance (M)-F and assisted living director in residence (ALDIR)-B provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN During an interview on April 3, 2025, at approximately 11:55 a.m., the surveyor requested a copy of the FSEP from ALDIR-B. The surveyor was directed to the emergency preparedness binder. Record review indicated the FSEP included the facility floor plan and a resident evacuation status list. Employee actions and resident protection procedures were not included	0 810		

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0 810	Continued From page 17 in the binder. During an interview on April 3, 2025, at 1:40 p.m., ALDIR-B stated FSEP employee actions and resident protection procedures should be included in the emergency preparedness binder and was not sure why it was missing. All parts of the FSEP must be maintained as readily available for all staff accessibility. Record review indicated the licensee FSEP was not developed with employee actions and resident protection procedures to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. A printed copy of an undated fire protection plan was provided to the surveyor for review. Record review indicated the employee actions in the fire protection plan were limited to activating the alarm system, assisting residents in danger, and utilizing fire extinguishers. Record review indicated specific evacuation procedures were not included in the plan. Evacuation procedures directed the building occupants to points of refuge, but these areas were not identified. The building occupants were directed to await evacuation in the dining room, no alternate evacuation locations were identified. During an interview on April 3, 2025, at 1:40 p.m., ALDIR-B verified the FSEP required revision. TRAINING Record review indicated the licensee failed to provide fire safety and evacuation training to residents at least once per year evident by the lack of documentation. During an interview on April 3, 2025, at approximately 11:55 a.m., ALDIR-B stated residents were trained at the time of admission, during resident council meetings, and when care plans were reviewed. The surveyor requested documentation to support resident training had been completed in the last year from ALDIR-B. ALDIR-B stated they would	0 810		

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0 810	Continued From page 18 check on what records were available. No further information was provided. Record review indicated the licensee failed to provide training to employees on the FSEP at least twice per year evident by the lack of documentation to support this had been completed. No FSEP training records were provided. During an interview on April 3, 2025, at approximately 12:00 p.m., M-F stated employees were trained during every fire drill and verified no FSEP training records had been maintained. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for three of three residents (R1, R2, R3). This practice resulted in a level one violation (a	0 910		

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0 910	Continued From page 19 violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1's start of services was February 28, 2024. R1's Service Plan dated February 28, 2024, indicated R1 received services including assistance with bathing and medication administration. R1's Resident Agreement dated February 28, 2024, lacked the name, telephone number, and physical mailing address of the licensee of the facility. R2 R2's start of services was November 22, 2024. R2's Service Plan dated December 2, 2024, indicated R2 received services including assistance with bathing, toileting, and medication administration. R2's Resident Agreement dated November 22, 2024, lacked the name, telephone number, and physical mailing address of the licensee of the facility. R3 R3's start of services was June 7, 2023. R3's Service Plan dated February 13, 2025,	0 910		

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0 910	Continued From page 20 indicated R3 received services including assistance with grooming, dressing, and medication administration. R3's Resident Agreement dated June 6, 2023, lacked the name, telephone number, and physical mailing address of the licensee of the facility. On April 3, 2024, at 10:20 a.m., assisted living director in residency (ALDIR)-B stated the same template was utilized for all contracts, and it was missing the above required content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910		
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 interview and record review, the	01760		

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01760	Continued From page 21 licensee failed to resolve medication errors to prevent recurrence for one of three residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3's diagnoses included type 2 diabetes mellitus, atrial fibrillation, chronic kidney disease, major depressive disorder, generalized anxiety disorder, repeated falls, intervertebral disc degeneration, osteoarthritis, carpal tunnel syndrome, neuropathy, myelopathy, and muscle weakness. R3's Service Plan dated February 13, 2025, indicated R3 received services including assistance with grooming, dressing, and medication administration. R3's Uniform Assessment Tool dated March 11, 2025, noted R3 had a pain score of 8, identified as a moderate pain intensity "More noticeable, causing some disruption." R3's record noted the following: - Medication Incident Report dated October 6, 2025, at 4:00 p.m., noted "Missed Medication" cephalexin (antibiotic medication) 500 milligrams (mg) was recorded as not available and later found to be in the medication cart. No adverse effects;	01760		

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01760	Continued From page 22 - Medication Incident Report dated October 6, 2024, at 8:00 p.m., noted "Missed Medication" cephalexin (antibiotic medication) 500 mg was recorded as not available and later found to be in the medication cart. No adverse effects; - Medication Incident Report dated December 20, 2024, at 8:04 p.m., noted "Missed Medication" pregabalin (used to treat neuropathic pain) 25 mg discovered medication was not given the previous night. Noted "increase in nerve pain"; - Medication Incident Report dated December 25, 2024, at 9:17 a.m., noted "Missed Medication" pregabalin 25 mg medication not given the previous day. R3 complained of "increased pain over the last few days" and nerve pain; - Medication Incident Report dated December 28, 2024, at 8:00 a.m., noted "Missed Medication" pregabalin 25 mg medication was documented as given but was still in the narcotic lock box. R3 reported increased pain over the last few days; - Medication Incident Report dated December 31, 2025, at 8:27 a.m., noted "Missed Medication" pregabalin 25 mg medication was not given. R3 reported increased nerve pain; - Medication Incident Report dated January 29, 2025, at 9:48 a.m., noted "Missed Medication" pregabalin 25 mg medication was not given. Staff reported not given because the medication was not available. However, the medication was in the narcotic cabinet in the nursing office, and not reported to nursing it was out on the medication cart. No adverse effects reported; and - Medication Incident Report dated February 3, 2025, at 8:00 p.m., noted "Missed Medication" trazodone (used to treat depression and to induce sleep) 50 mg medication was not given. Staff punched the medication from the pack but it did not come out of the package. No adverse effects reported.	01760		

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01760	Continued From page 23 On April 3, 2025, at 11:50 a.m., clinical nurse supervisor (CNS)-A stated the action taken related to the incidents included: - October 6, 2024, at 4:00 p.m., staff involved was reeducated; - October 6, 2024, at 8:00 p.m., staff involved was reeducated. Provider notified and the missed doses were added to the end of the cycle; - December 20, 2024, at 8:04 p.m., contacted agency and asked this particular staff not return; - December 25, 2024, at 9:17 a.m., contacted staffing agency and asked staff not return. Reeducation provided to all staff; - December 28, 2024, at 8:00 a.m., staff was removed from medication pass duties; - December 31, 2024, at 8:27 a.m., contacted staffing agency and staff education provided to the staff involved ; - January 29, 2025, at 9:48 a.m., instructions were added into the electronic medication administration record that the pregabalin was located in the locked narcotic box in the medication cart; - February 3, 2025, at 8:00 p.m., staff involved was reeducated. On April 3, 2025, at 8:15 a.m., R3 reported she did not know if she had a change in her pain level with the mediation errors because she always had pain. The licensee's Medication Errors policy dated April 4, 2025, noted the internal investigation of a medication error led by the registered nurse would include whether any corrective action needed to systems, training or other procedures was identified to reduce the risk of further occurrence. No further information provided.	01760		

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01760	Continued From page 24 TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure current written or electronically recorded prescriptions were obtained for one of three residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on March 31, 2025, at 10:00 a.m., assisted living director in residency (ALDIR)-C stated the licensee provided medication management services to residents at the facility. R1's record lacked signed prescriber orders.	01820		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01820	Continued From page 25 R1's diagnoses included gastro-esophageal reflux disease, major depressive disorder, hypertension, and chronic obstructive pulmonary disease. On April 1, 2025, at 8:15 a.m., the surveyor observed ULP-D administer medications to R1 in his apartment. R1's Service Plan dated February 28, 2024, indicated R1 received services including assistance with bathing and medication administration. R1's March 2025, Medication Administration Record included: - doxycycline hyclate 100 milligram (mg) two times daily (antibiotic). R1's provider orders dated December 3, 2024, lacked an order for doxycycline. On April 3, 2025, at 10:50 a.m., clinical nurse supervisor (CNS)-A stated she was unable to locate an order in R1's record for the doxycycline. The licensee's Medication Management policy dated January 16, 2023, noted there must be a written or electronic prescription for medications managed by the licensee. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20187	A. BUILDING: _____ B. WING _____	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRAINERD CAREFREE LIVING LLC	2723 OAK STREET BRAINERD, MN 56401

(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
02310	Continued From page 26 (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on 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 (R3) with hospital bedrails. 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: R3's diagnoses included type 2 diabetes mellitus, hypothyroidism, atrial fibrillation, intervertebral disc degeneration, and obesity. On April 3, 2025, at 12:22 p.m., the surveyor observed R3's bed with clinical nurse supervisor (CNS)-A to be a hospital style bed with bilateral hospital bedrails in the raised position at the head of the bed. The bedrails were a metal material with eight vertical bars between the entire rail frame. CNS-A measured as follows; - zone 1 (within the rails) from 2 inches to 3 1/2 inches; - zone 2 (under the rail, between the rail supports	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20187	A. BUILDING: _____ B. WING _____	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRAINERD CAREFREE LIVING LLC	2723 OAK STREET BRAINERD, MN 56401

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02310	Continued From page 27 or next to a single rail support) 0 inches; - zone 3 (between the rail and the mattress) 0 to 1 inch; and - zone 4 (under the rail, at the ends of the rail) 0 inches. R3's Service Plan dated February 13, 2025, indicated R3 received services including assistance with grooming, dressing, and medication administration. R3's Uniform Assessment Tool dated March 11, 2025, noted R3 reported pain, had partial bladder incontinence, and required assistance of two staff and a mechanical lift for transfers. However, R3's record lacked measurements of the bedrails. On April 3, 2025, at 11:20 a.m., CNS-A stated the bedrail measurements were not documented in R3's record as required. The licensee's Assessing Bed Assist Devices policy dated June 8, 2022, noted when a resident had a bedrail, the registered nurse would assess and determine whither it met the FDA standards for bedrails. The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment with hospital beds, zone 1 (within the rail) should not exceed 4 and 3/4 inches, zone 2 (under the rail, between rail supports or next to a single rail support) should not exceed 4 and 3/4 inches, zone 3 (between the rail and the mattress), should not exceed 4 and 3/4 inches, and zone 4 (under the rail, at the ends of the rail) should not exceed 2 and 3/8 inches or be greater than a 60 degree angle.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20187	A. BUILDING: _____ B. WING _____	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRAINERD CAREFREE LIVING LLC	2723 OAK STREET BRAINERD, MN 56401

(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
02310	Continued From page 28 The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) last updated December 13, 2024, indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". The MDH website, Assisted Living Resources & Frequently-Asked Questions (FAQs) also indicated "licensees should refer to individual manufacturer's guidelines for appropriate installation, maintenance and use. In addition,	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20187	A. BUILDING: _____ B. WING _____	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRAINERD CAREFREE LIVING LLC	2723 OAK STREET BRAINERD, MN 56401

(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
02310	Continued From page 29 licensees should refer to the Consumer Product Safety Commission (CSPC) for the most up-to-date information related to portable bed side rail recall information." 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." No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	02310		

Minnesota Department of Health
Food, Pools, and Lodging
PO Box 64975
St. Paul, MN 55164
651-201-4500

Type: Full
Date: *03/31/25*
Time: 11:50:45
Report: 1037251087

Food and Beverage Establishment Inspection Report

Location:
Brainerd Carefree Living Llc
2723 Oak Street
Brainerd, MN56401
Crow Wing County, 18

Establishment Info:
ID #: 0038419
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2188298622
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.

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) ***** Priority 1 *****

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

RAW SHELLED EGGS WERE BEING STORED ABOVE PACKAGED PRECOOKED PASTA AND CANNED SODA IN THE WALK-IN COOLER. STORE ALL RAW ANIMAL FOODS BELOW READY TO EAT FOODS.

Comply By: 03/31/25

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

3-304.14B

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

EMPLOYEE OBSERVED WIPING THE COUNTER TOP WITH A SOILED, DRY WIPING CLOTH. STORE WIPING CLOTHS IN AN APPROVED SANITIZING SOLUTION.

Comply By: 03/31/25

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.

ANSUL AND FIRE EXTINGUISHERS WERE LAST TAGGED AND SERVICED MARCH 2024. SERVICE ANNUALLY. SERVICE AND TAG THE FIRE SUPPRESSION SYSTEM AND ALL FIRE EXTINGUISHERS.

Comply By: 04/30/25

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.

ICE MAKER DOOR IS BROKEN AND COVERED IN TAPE AROUND EDGES AND CORNERS. REPAIR TO ELIMINATE TAPE OR REPLACE DOOR.

Comply By: 05/31/25

4-600 Cleaning Equipment and Utensils

4-602.11E

MN Rule 4626.0845E Clean surfaces contacting food that is not TCS: 1. at any time when contamination may have occurred; 2. at least once every 24 hours for iced tea dispensers and consumer self-service utensils; 3. before restocking consumer self-service equipment and utensils such as condiment dispensers, and display containers; 4. at a frequency specified by the manufacturer or at a frequency necessary to preclude accumulation of soil or mold for ice bins, beverage dispensing nozzles, enclosed components of ice makers, cooking oil storage tanks and distribution lines, beverage and syrup dispensing lines or tubes, coffee bean grinders, and water vending equipment.

PINK MOLD OBSERVED ON THE INSIDE OF THE ICE MAKER. CLEAN AND MAINTAIN CLEAN.

Comply By: 03/31/25

5-200A Plumbing: approved materials/design

5-201.11B

MN Rule 4626.1040B Maintain the plumbing system in good repair.

GARBAGE DISPOSAL / GREASE TRAP ADJACENT TO THE DISH MACHINE WAS REMOVED LEAVING A HOLE IN THE COUNTER WITH A CATCH BUCKET BELOW. CONTACT LICENSED PLUMBER TO REPAIR PLUMBING TO ELIMINATE HOLE.

Comply By: 06/30/25

Surface and Equipment Sanitizers

Chlorine: = 100 at Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Quaternary Ammonia: = 400 at Degrees Fahrenheit
Location: SANITIZING BUCKET - DINING AREA
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Walk-In Cooler
Temperature: 39 Degrees Fahrenheit - Location: MILK JUG
Violation Issued: No

Process/Item: Hot Holding
Temperature: 146 Degrees Fahrenheit - Location: BAKED BEANS
Violation Issued: No

Type: Full
Date: *03/31/25*
Time: 11:50:45
Report: 1037251087
Brainerd Carefree Living Llc

Food and Beverage Establishment Inspection Report

Process/Item: Hot Holding
Temperature: 150 Degrees Fahrenheit - Location: BONELESS PORK RIB
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: MILK JUG
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	1	0	5

DISCUSSED BARE HAND CONTACT, EMPLOYEE ILLNESS RECORDING, MENU, COOLING, REHEATING, AND ORDERS.

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 1037251087 of 03/31/25.

Certified Food Protection Manager: SARA LYNN MORLANG

Certification Number: 104334 Expires: 06/26/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
LANITA

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

Report #: 1037251087

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools, and Lodging
PO Box 64975
St. Paul, MN 55164

No. of RF/PHI Categories Out	2
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 03/31/25
Time In 11:50:45
Time Out

Brainerd Carefree Living Llc	Address: 2723 Oak Street	City/State: Brainerd, MN	Zip Code: 56401	Telephone: 2188298622
License/Permit #: 0038419	Permit Holder	Purpose of Inspection: Full	Est Type	Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item. Mark "X" in appropriate box for COS and/or R.

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

Compliance Status		COS	R
Supervision			
1	IN OUT	PIC knowledgeable; duties & oversight	
2	IN OUT N/A	Certified food protection manager, duties	
Employee Health			
3	IN OUT	Mgmt/Staff;knowledge,responsibilities&reporting	
4	IN OUT	Proper use of reporting, restriction & exclusion	
5	IN OUT	Procedures for responding to vomiting & diarrheal events	
Good Hygenic Practices			
6	IN OUT N/O	Proper eating, tasting, drinking, or tobacco use	
7	IN OUT N/O	No discharge from eyes, nose, & mouth	
Preventing Contamination by Hands			
8	IN OUT N/O	Hands clean & properly washed	
9	IN OUT N/A N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed	
10	IN OUT	Adequate handwashing sinks supplied/accessible	
Approved Source			
11	IN OUT	Food obtained from approved source	
12	IN OUT N/A N/O	Food received at proper temperature	
13	IN OUT	Food in good condition, safe, & unadulterated	
14	IN OUT N/A N/O	Required records available; shellstock tags, parasite destruction	
Protection from Contamination			
15	IN OUT N/A N/O	Food separated and protected	
16	IN OUT N/A	Food contact surfaces: cleaned & sanitized	
17	IN OUT	Proper disposition of returned, previously served, reconditioned, & unsafe food	

Compliance Status		COS	R
Time/Temperature Control for Safety			
18	IN OUT N/A N/O	Proper cooking time & temperature	
19	IN OUT N/A N/O	Proper reheating procedures for hot holding	
20	IN OUT N/A N/O	Proper cooling time & temperature	
21	IN OUT N/A N/O	Proper hot holding temperatures	
22	IN OUT N/A	Proper cold holding temperatures	
23	IN OUT N/A N/O	Proper date marking & disposition	
24	IN OUT N/A N/O	Time as a public health control: procedures & records	
Consumer Advisory			
25	IN OUT N/A	Consumer advisory provided for raw/undercooked food	
Highly Susceptible Populations			
26	IN OUT N/A	Pasteurized foods used; prohibited foods not offered	
Food and Color Additives and Toxic Substances			
27	IN OUT N/A	Food additives: approved & properly used	
28	IN OUT	Toxic substances properly identified, stored, & used	
Conformance with Approved Procedures			
29	IN OUT N/A	Compliance with variance/specialized process/HACCP	

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

GOOD RETAIL PRACTICES

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

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

			COS	R
Safe Food and Water				
30	IN OUT N/A	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT N/A	Variance obtained for specialized processing methods		
Food Temperature Control				
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A N/O	Plant food properly cooked for hot holding		
35	IN OUT N/A N/O	Approved thawing methods used		
36		Thermometers provided & accurate		
Food Identification				
37		Food properly labled; original container		
Prevention of Food Contamination				
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41	X	Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
Proper Use of Utensils				
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
Utensil Equipment and Vending				
47	X	Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51	X	Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 03/31/25

Inspector (Signature)