DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

February 3, 2025

Licensee
Shepherds Inn Assisted Living
46 1st Avenue Southwest
Wells, MN 56097

RE: Project Number(s) SL30320015

Dear Licensee:

On November 21, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the September 5, 2024, 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,

Benjamin J. Zwart, P.E., Supervisor
State Engineering Services Section
Health Regulation Division
Email: Benjamin.Zwart@state.mn.us
Telephone: 651-201-3715 Fax: 1-866-890-9290

JMD

Electronically Delivered

October 16, 2024

Licensee
Shepherds Inn Assisted Living
46 1st Avenue Southwest
Wells, MN 56097

RE: Project Number(s) SL30320015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 5, 2024, 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 . . ."

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

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

The correction order documentation should include the following:

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

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

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. 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,

Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30320	A. BUILDING: _____ B. WING _____	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEPHERDS INN ASSISTED LIVING	46 1ST AVENUE SW WELLS, MN 56097

(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: SL30320015-0 On September 3, 2024, through September 5, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 16 residents; 12 receiving services under the Assisted Living 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.	
0 470 SS=C	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 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 staff posting included all the required elements, potentially affecting all the licensee's current residents, staff, and visitors. This practice resulted in a level one violation (a 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	0 470		

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0 470	Continued From page 2 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings included: During the entrance conference on September 3, 2024, at 10:30 a.m. licensee owner (O)-A stated the staffing shift hours were as follows: Day shift: one unlicensed personnel (ULP) 6:30 a.m. - 3:00 p.m. and one ULP 4:00 a.m. - 8:00 a.m.; evening shift: one ULP 3:00 p.m. - 11:00 p.m. and one ULP 4:00 p.m. - 8:00 p.m.; night shift: 11:00 p.m. - 4:00 a.m. On September 3, 2024, at 11:02 a.m. the daily staff schedule was observed posted on a white board in the dining room. The staff schedule included how many unlicensed staff were working for the AM, PM, and overnight shift; the schedule did not indicate the specific times of each shift. O-A reviewed the staff schedule and stated the shift times were not included. The licensee's Staffing Plan last reviewed July 18, 2024, included baseline requirements: - nurse in house various days, Monday-Friday, during daytime hours; - nurse available 24/7 on call via phone or text; - one awake staff on duty 24/7; - overnight staff and day shift staff overlap for morning cares, showers, and medications; - one staff on duty 4:00 p.m. - 7:00 p.m. daily to assist evening shift staff with resident evening needs. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 470		

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0 470	Continued From page 3 (21) 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 document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated September 3, 2024, 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 to the FBEIR for any compliance dates.	0 480		

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0 550	Continued From page 4	0 550		
0 550 SS=C	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post in a conspicuous place, the email contact information for the individuals responsible for handling resident grievances. This had the potential to affect the licensee's current residents, staff, and visitors. This practice resulted in a level one violation (a 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).	0 550		

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0 550	Continued From page 5 The findings include: On September 3, 2024, at 11:02 a.m., the surveyor toured the facility and observed the posted grievance procedure in the front entrance. The procedure included the name and telephone number for the individual responsible for handling grievances but lacked the email contact information. On September 3, 2024, at 12:20 p.m., owner (O)-A stated the form lacked the email contact information and was not aware this was required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	0 640		

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0 640	Continued From page 6 review, the licensee failed to support protection and safety by not posting information and phone number for 911 emergency number as required. 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, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee failed to: - post the 911 emergency number in common areas and near telephones provided by the assisted living facility. During the facility tour on September 3, 2024, at 11:02 a.m. the surveyor observed the common areas within the facility and noted there was no posting of the 911 emergency number as required. On September 3, 2024, at 12:22 p.m. owner (O)-A stated the 911 emergency number was not posted in common areas or near facility telephones. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		

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0 660	Continued From page 7	0 660		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) to include an annual facility TB risk assessment. 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:	0 660		

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0 660	Continued From page 8 The licensee lacked a facility TB Risk Assessment. On September 3, 2024, at 2:11 p.m. clinical nurse supervisor (CNS)-B stated the TB Risk Assessment had not been completed annually as required and was not aware of the requirement. The MN Department of Health Facility Tuberculosis (TB) Risk Assessment Instructions and Worksheet for Health Care Setting Licensed by MDH updated June 2024, indicated: Settings should perform a facility risk assessment on an annual basis. The worksheet further indicated all Minnesota health care personnel should receive TB education annually, regardless of facility risk level classification. TB education should include information on TB exposure (both occupational and non-occupational) risk factors, the signs and symptoms of TB disease, and TB infection control policies and procedures. The licensee's TB Prevention and Control policy dated August 26, 2024, indicated the clinical nurse supervisor was responsible for establishing and maintaining the TB prevention and control program including: b. Completion of a written TB risk assessment for the agency using the form provided by the Minnesota Department of Health. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680		

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0 680	Continued From page 9 (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 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 post an emergency disaster plan prominently, post exit diagrams on each floor, and failed to develop an all-hazards risk assessment emergency preparedness (EP) plan. 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	0 680		

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0 680	Continued From page 10 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: POST AN EMERGENCY DISASTER PLAN PROMINENTLY During the facility tour on September 3, 2024, at 11:02 a.m. the surveyor observed there was no signage posted, or information regarding the licensee's emergency preparedness plan. On September 3, 2024, at 12:45 p.m. owner (O)-A stated the EP binder was kept in the licensed assisted living director's office and the plan was not posted within the facility. POST EMERGENCY EXIT DIAGRAMS ON EACH FLOOR During the facility tour on September 3, 2024, at 11:02 a.m. the surveyor observed there was no emergency exit diagrams in the hallways of the main floor of the licensee's building. On September 3, 2024, at 12:45 p.m. O-A stated there were no emergency exit postings on each floor as required. EMERGENCY PREPAREDNESS PLAN CONTENT The licensee's EP plan consisted of several documents and policies in a white three-ringed binder dated reviewed August 28, 2024. The book included various policies/procedures related to communication, collaboration, subsistence needs, sheltering in place, evacuation, weather events, and fire. However, the licensee lacked a	0 680		

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0 680	Continued From page 11 customized EP plan to include the following required content: - Hazard vulnerability assessment. On September 4, 2024, at 1:45 p.m. O-A stated the licensee's EP plan lacked the above required component. O-A further stated she was aware of the EP plan requirements but had not completed the hazard vulnerability assessment for the facility yet. The licensee's 2.01 Policies & Procedures Overview policy noted the facility would maintain an emergency plan in accordance to state and federal guidelines. The emergency plan would: A. Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. Per Assisted Living Facilities: Minnesota Rules Chapter 4695, 4659.0100, sections A and B, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment	0 790		

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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
0 790	Continued From page 12 (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. This deficient condition 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) 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 facility tour on September 5, 2024, from 9:15 a.m. through 10:10 a.m., with owner/maintenance (OM)-E, the surveyor observed that the fire extinguishers located in the salon, in the corridor outside the salon and in the mechanical room lacked records indicating monthly inspections had been performed. The fire	0 790		

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	30320	A. BUILDING: _____ B. WING _____	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEPHERDS INN ASSISTED LIVING	46 1ST AVENUE SW WELLS, MN 56097

(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
0 790	Continued From page 13 extinguisher in the mechanical room had a tag indicating annual testing was completed by a third party in February of 2023, which was more than one year ago. Documentation is required to demonstrate fire extinguishers have been inspected by facility personnel monthly, and annually replaced with a new extinguisher or serviced annually by a certified technician. During the tour OM-E verified the monthly inspections had not been completed. OM-E stated that the fire extinguisher in the mechanical room was overlooked when the other extinguishers had received the annual testing. OM-E stated they understood the requirement. 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) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall	0 810		

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0 810	Continued From page 14 receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content and failed to conduct the required training and drills. 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 September 5, 2024, owner/maintenance	0 810		

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0 810	Continued From page 15 (OM)-E, 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 The licensee's FSEP, titled "Fire Emergency Plan", updated September, 2023, failed to provide the following: The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. During an interview on September 5, 2024, at 11:05 a.m., OM-E stated they understood the areas of the policy that were incomplete and would work on bringing them into compliance. TRAINING Record review indicated the licensee failed to provide evacuation training based on the fire safety and evacuation plan to residents, at least once per year as evident by not providing documentation of training offered or training scheduled for a future date. Record review indicated the licensee failed to provide evacuation training based on the fire safety and evacuation plan to employees, at hire and twice per year as evident by not providing documentation of training offered or training scheduled for a future date. During an interview on September 5, 2024, at 11:05 a.m., OM-E stated that they were not aware	0 810		

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0 810	Continued From page 16 of the requirement. The surveyor showed OM-E where the requirement for training was stated in their policy. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month as evident by providing documentation showing evacuation drills conducted quarterly. During an interview on September 5, 2024, at 11:05 a.m., OM-E stated that they were not aware of the requirement. The surveyor showed OM-E where the requirement for evacuation drills was stated in their policy. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 820 SS=D	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction.	0 820		

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0 820	Continued From page 17 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect a limited number of residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: During facility tour on September 5, 2024, from 9:15 a.m. through 10:10 a.m., with owner/maintenance (OM)-E, the surveyor observed that the emergency exit door located near resident room 9 had a keyed lock on the facility side of the door. There was an exit sign mounted above the door and the door was shown as an emergency exit on the posted evacuation maps. Emergency exit doors must be operable without the use of keys or special knowledge. OM-E verified the deficient condition while accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) days.	0 820		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the	01060		

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01060	Continued From page 18 facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes	01060		

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01060	Continued From page 19 a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R1 R1 began receiving assisted living services on November 22, 2022. R1's Service Plan dated June 26, 2024, indicated R1 received services including bathing and medication administration. R1's Resident Notes dated May 17, 2024, at 6:34 a.m. indicated R1 was taken to the emergency room via ambulance for left hip pain following a fall in her room. Resident Notes dated June 26, 2024, at 5:22 p.m. identified R1 returned to the facility following a rehabilitation stay. R2 R2's Service Plan dated June 19, 2024, indicate	01060		

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01060	Continued From page 20 R2 received services including bathing and medication administration. R2's Resident Notes dated April 7, 2024, at 6:40 p.m. indicated R2 was taken to the emergency room via ambulance for complaints of back pain following a fall in her bathroom. Resident Notes dated June 19, 2024, at 2:06 p.m. identified R2 returned to the facility following a rehabilitation stay. R1 and R2's record lacked a written notice that contained, at a minimum: - the reason for the relocation. - the name and contact information for the location to which the resident has been relocated and any new service provider. - contact information for the Office of Ombudsman for Long-Term Care. - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known. - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. In addition, R1 and R2's record lacked notification to the OOLTC that they had been relocated and had not returned to the facility within four days. On September 4, 2024, at 1:31 p.m. clinical nurse supervisor (CNS)-B stated no written notice was provided to R1, R2, or any residents that had been emergently relocated. CNS-B further stated the OOLTC had not been notified if residents had not returned to the facility within four days.	01060		

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01060	Continued From page 21 CNS-B stated she was not aware of the emergent relocation regulation. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days	01060		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for	01370		

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01370	Continued From page 22 the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care for one of two employees (unlicensed personnel (ULP)-C). 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: ULP-C was hired on December 18, 2023, as a cook and moved into a direct care position on July 21, 2024, to provide direct care services to residents at the assisted living. On September 4, 2024, at 7:40 a.m. ULP-C was observed to administer medications to R2 in her room.	01370		

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01370	Continued From page 23 ULP-C's record lacked evidence the following competencies had been completed prior to providing direct cares: -appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; On September 5, 2024, at 9:10 a.m. clinical nurse supervisor (CNS)-B stated the above topics were lacking from ULP-C's employee file. The licensee's Assisted Living Orientation-ULP Staff policy dated reviewed/revised June 15, 2023, identified in addition to training all staff receive, ULP who are not a registered nursing assistant would receive additional training with a written or oral competency test and a skill demonstration on the above missing topics. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring	01650		

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01650	Continued From page 24 assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a service plan included the required content for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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:	01650		

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01650	Continued From page 25 R1 R1's Service Plan dated June 26, 2024, indicated R1 received services including bathing and medication administration. However, it lacked: - the schedule and methods of monitoring assessments of the resident; and - the schedule and methods of monitoring staff providing services. R2 R2's Service Plan dated June 19, 2024, indicate R2 received services including bathing and medication administration. However, it lacked: - the schedule and methods of monitoring assessments of the resident; and - the schedule and methods of monitoring staff providing services. On September 4, 2024, at 1:38 p.m., clinical nurse supervisor (CNS)-B stated the content was lacking on the service plans as noted above and stated the same format was utilized for all residents within the facility. The licensee's Contents of Service Plans policy dated April 8, 2024, noted the service plan would include the schedule and methods of monitoring assessments and the schedule and methods of monitoring staff providing services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		

DEPARTMENT OF HEALTH

Type: Full
Date: *09/03/24*
Time: 11:15:00
Report: 1033241168

Food and Beverage Establishment Inspection Report

Location:
The Shepherds Inn
46 1st Avenue Sw
Wells, MN56097
Faribault County, 22

Establishment Info:
ID #: 0038602
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5075536271
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.

4-300 Equipment Numbers and Capacities
4-302.12B ***** Priority 2 *****
MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

Facility does not have a small diameter probe.
Comply By: 09/17/24

4-300 Equipment Numbers and Capacities
4-302.13B ***** Priority 2 *****
MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

Facility does not have a high temperature thermometer probe.
Comply By: 09/17/24

4-300 Equipment Numbers and Capacities
4-302.14 ***** Priority 2 *****
MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

Facility does not have sanitizer test strips.
Comply By: 09/17/24

4-600 Cleaning Equipment and Utensils

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

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

Can opener blade has visible food debris on it.

Comply By: 09/03/24

5-200C Plumbing: Maintenance, fixture location

5-205.11AB ***** Priority 2 *****

MN Rule 4626.1110AB The handwashing sink must be accessible at all times for employee use, and must be used only for handwashing.

Cleaning bucket is stored in the handwashing sink.

Comply By: 09/03/24

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.

Soiled rags observed on the counters.

Comply By: 09/03/24

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.

Facility is using household crockpots and a fryer.

Comply By: 09/03/24

Surface and Equipment Sanitizers

Hot Water: = at 160 Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

Acid: = 1875 at Degrees Fahrenheit
Location: Spray Bottle
Violation Issued: No

Food and Equipment Temperatures

Type: Full
Date: *09/03/24*
Time: 11:15:00
Report: 1033241168
The Shepherds Inn

Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding
Temperature: 0> Degrees Fahrenheit - Location: Walk In Freezer
Violation Issued: No

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: Chicken-Walk In Cooler
Violation Issued: No

Process/Item: Cooking
Temperature: 203 Degrees Fahrenheit - Location: Chicken-Oven
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	5	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 1033241168 of 09/03/24.

Certified Food Protection Manager: Heather S Tilghman

Certification Number: FM107503 Expires: 08/26/27

Inspection report reviewed with person in charge and emailed.

Signed: _____
Heather S Tilghman

Signed: _____
Isaiah Armendariz
Environmental Health Specialist
Mankato District Office
507-344-2743
isaiah.armendariz@state.mn.us

Report #: 1033241168

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

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

Date 09/03/24
Time In 11:15:00
Time Out

The Shepherds Inn	Address: 46 1st Avenue Sw	City/State: Wells, MN	Zip Code: 56097	Telephone: 5075536271
License/Permit #: 0038602	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
Surpervision			
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	X	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	X	Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 09/04/24

Inspector (Signature)