Electronically Delivered

July 27, 2022

Administrator
Autumn Cottages by Knute Nelson
812 McKay Avenue South
Alexandria, MN 56308

RE: Project Number SL30736015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on June 14, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

The enclosed State Form documents the state licensing orders. The Department of Health 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 imposed immediately with no opportunity to correct the violation first as follows:

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

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation

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

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction 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 issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should be addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Jessica Sellner, RN, Supervisor
Office of Health Facility Complaints
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, MN 55164-0970
Email: jessica.sellner@state.mn.us
Phone: 320-223-7370
Fax: 651-215-6894

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30736	A. BUILDING: _____ B. WING _____	06/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN COTTAGES BY KNUTE NELSON	812 MCKAY AVENUE SOUTH ALEXANDRIA, MN 56308

(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 Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#30736015 On, June 13, 2022, through June 14, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 16 residents, all of whom received services under the provider's Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request	0 460		

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0 460	Continued From page 1 assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide a means to request staff assistance for the residents health and safety needs 24 hours a day, seven days a week. This had the potential to affect all 16 residents at the facility. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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:	0 460		

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0 460	Continued From page 2 On June 13, 2022, at 11:30 a.m. during the entrance conference licensed practical nurse (LPN)-A and the Licensed Assisted Living Director (LALD)-E stated the facility had no call light system for residents to request staff assistance. R3 was admitted to the facility on November 15, 2019, with diagnoses including dementia with behavioral disturbances, and aphasia following cerebral infarction. R3's care plan indicated she was able to communicate and make her needs known. The care plan indicated R3 was at risk for falls due to impulsive self -transfers and was encouraged to call for assistance when needed. However, the care plan indicated R3 was unable to use a call pendant system, and the facility had no call light system in place for R3 to summon for assistance. On June 14, 2022, at approximately 11:30 a.m. LALD-E stated the facility planned to offer jingle bells on a hand strap for residents to summon assistance until a more permanent summoning system could be implemented. During email communication on June 15, at 10:58 a.m. the LALD-E stated there was no specific policy for summoning devices. The LALD-E indicated staff completed routine checks on residents, or the residents were brought to family room spaces where staff was able to keep eyes on them. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 460		

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0 480	Continued From page 3	0 480		
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: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (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 according to the Minnesota Food Code. This had the potential to affect all 16 residents who resided in the facility. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients). The findings include:	0 480		

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0 480	Continued From page 4 Please refer to the additional documentation included in the Food and Beverage Establishment Inspection Reports, dated June 13, 2022. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: 0800 Based on observation and interview, the licensee failed to maintain the facility physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents).	0 800		

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0 800	Continued From page 5 The findings include: On June 13, 2022, from approximately 12:35 p.m. to 1:20 p.m., survey staff toured the facility with Maintenance Manager (MM)-E. During the facility tour, survey staff observed and verified padlocks installed on the memory courtyard gates. The gates were locked from the outside which removed a safe means of egress during a fire or similar emergency. This was evident as the memory care unit had two identified exit doors inside the building directing people to exit into the locked courtyard. This proposed exit path was also shown on the facility's evacuation plan. On June 13, 2022, at approximately 1:10 p.m., MM-E verbally confirmed survey staff observations. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique	0 810		

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0 810	Continued From page 6 or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees 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: 0810 Based on observation, interview and record review, the licensee failed to provide the required fire safety training and evacuation plans for residents and staff. This has 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, 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 the potential to affect a large portion or all residents).	0 810		

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0 810	Continued From page 7 The findings include: On June 13, 2022, from approximately 12:35 p.m. to 1:20 p.m., survey staff toured the facility with Maintenance Manager (MM)-E. During the facility tour, survey staff observed the facility fire safety and evacuation plan documentation was requested and was noted to lack the following. 1. Documentation of required employee evacuation drills did not show drills being done every other month. 2. The schedule and required records on training of employees on fire safety and evacuation. 3. The schedule and required records on training of residents who can assist their own evacuation on proper actions to take in the event of a fire for their safety including movement, evacuation, and relocation. On June 13, 2022, at approximately 1:20 p.m. MM-E was not able to provide the information listed above as requested. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01690 SS=F	144G.71 Subdivision 1 Medication management services (a) This section applies only to assisted living facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and	01690		

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01690	Continued From page 8	01690		

procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines.
(c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review the licensee failed to implement medication management of controlled drugs to ensure security and accountability to prevent potential diversion. This practice had the potential to affect all 16 residents who resided in the facility.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a

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01690	Continued From page 9 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 observation on June 14, 2022, at 9:35 a.m. with unlicensed personnel (ULP)-C, the facility medication black controlled drug log book, which was kept in the medication cart lock box, was observed to have 21 blank line entries from number line 54 to 58, and 60 to 73. ULP-C stated the medications were not logged into index, and should have been done by whatever staff received the medication. ULP-C stated the shift to shift count this morning was correct, however, she was not the staff who had completed the count. ULP-C stated two other staff counted and handed her the keys and stated the count was correct, but indicated she had not verified or counted the controlled drugs before starting her shift. ULP-C stated staff do not utilize the index to count medications but instead pulled the medication from the lock box, look at the number on the medication card, and then went to the corresponding page to verify the count. On June 14, 2022, at 9:48 a.m. licensed practical nurse (LPN)-A stated a shift to shift narcotic medication count was done with someone from the current shift and with a staff from the oncoming shift, not necessarily the staff who are passing medications. After the narcotic medication count, the keys are given to the person assigned to pass medications. LPN-A stated the staff responsible and passing medications was not always the staff completing the shift to shift narcotic count. LPN-A stated when a controlled drug comes into the facility	01690		

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staff verified the medication and logged it into the narcotic index and corresponding page for tracking. LPN-A verified multiple lines were blank in the narcotic index log book and indicated they should be filled in by who ever received the medication. LPN-A stated the process for the shift to shift narcotic count was done by staff pulling out the narcotic medication and then going to the corresponding page and the person looking at the book would verify the count was correct. LPN-A indicated they did not use the narcotic index when completing a shift to shift count to verify all controlled drugs logged into the facility were accounted for.

On June 14, 2022, at 10:18 a.m. Registered Nurse (RN)-D stated when a narcotic medication enters the facility it should be checked in by a licensed nurse and put into the narcotic log book and index. RN-D stated two staff should complete a shift to shift narcotic count using the index to verify all controlled drugs are accounted for, and then go to the corresponding page in the book to verify the number or amount is correct. RN-D stated discontinued or completed medications should be yellowed out, and the active medications in the index should be used to complete the shift-to-shift count.

The facility policy titled Medication Management Services dated August 1, 2021, indicated the RN would develop and update as needed specific medication management procedures including controlling and storing medications including controlled drugs.

The facility policy titled Controlled Substances/Scheduled II Drugs dated October 29, 2021, indicated the facility would take all reasonable measures to prevent diversion or

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01690	Continued From page 11 misuse of controlled substances. It would be clearly defined who was authorized to keys with access to controlled drugs and controlled drugs would be counted at the change of shift. The policy failed to indicate the staff responsible for medication administration on the previous shift would completed the shift to shift count with the staff coming on and assuming reasonability access of the controlled drugs. The facility policy titled Controlled Medication Count Verification dated December 3, 2021, indicated the narcotic record book was used to maintain documentation of removal of controlled substances from secure storage location for either administration to the resident or disposal. The policy indicated each controlled substance had a separate page with required information for each medication. Upon receiving controlled medication from the pharmacy each one should be logged into Narcotic Record Book individually and into the index page. The policy indicated the index page of the Narcotic Record Book was used to maintain an overall record of active controlled medications in the facility. Controlled medications would be reconciled at the end of each shift by two staff. The policy failed to instruct staff in the process for completing the end of shift count to include using the index to ensure all controlled substances in the facility were accounted for. TIME PERIOD FOR CORRECTION: Seven (7) days	01690		
03000 SS=D	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30736	A. BUILDING: _____ B. WING _____	06/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN COTTAGES BY KNUTE NELSON	812 MCKAY AVENUE SOUTH ALEXANDRIA, MN 56308

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03000	Continued From page 12	03000		

been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless:
(1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or
(2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4).
(b) A person not required to report under the provisions of this section may voluntarily report as described above.
(c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point.
(d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.
(e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common

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	30736	A. BUILDING: _____ B. WING _____	06/14/2022

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03000	Continued From page 13	03000		

entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to report potential maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC) and complete an investigation of potential maltreatment after one of one resident, R3, had repeated unwitnessed falls and sustained physical injuries including a fractured ankle and fractured rib.

This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety) and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

Findings Include:

R3 was admitted to the facility on November 15, 2019, with diagnoses including dementia with behavioral disturbances, and aphasia following a cerebral infarction.

R3's care plan dated April 20, 2022, indicated she was able to communicate and make her needs known. R3 was at risk for falls due to impulsive self -transfers and was encouraged to call for assistance when needed. However, the care

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	30736	A. BUILDING: _____ B. WING _____	06/14/2022

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03000	Continued From page 14	03000		

plan indicated R3 was unable to use a call pendant system, and the facility had no call light system in place for R3 to summon for assistance.

A fall incident report dated April 24, 2022, at 9:58 p.m. indicated R3 had two falls; one at 3:40 p.m., and one at 5:50 p.m. when she was found on the floor. The incident report indicated the first time R3 appeared to have gotten tangled in the blankets and fell off her bed. The report indicated the second fall she was found on the floor next to her door and yelled for help. There was no documenting or assessment regarding why or how the resident fell. R3 had pain in her right heel with range of motion, and had hit her head and stated she had lost her balance. The report indicated the RN was notified at 10:18 p.m. with instructions to complete a head injury report.

A facility progress note dated April 25, 2022, at 9:19 a.m. indicated R3 had three falls over the weekend and was complaining of pain in her right ankle and was unable to bear weight.

A progress note dated April 27, 2022, at 9:01 a.m. indicated a rounding provider ordered an X-ray of R3's right ankle.

The document titled "Professional Portable X-ray" dated April 27, 2022, indicated R3 had an evulsion fracture fragment of the right posterior heel and was ordered to wear a walking boot during the day and follow up on next rounds. The order indicated if the boot made R3 unsteady and at a higher risk for falling to please hold on the boot.

A fall incident report dated April 30, 2022, at 10:30 p.m. indicated R3 had impaired memory, was oriented to person only, and was wheelchair

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	30736	A. BUILDING: _____ B. WING _____	06/14/2022

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03000	Continued From page 15	03000		

bound due to previous injury. The report indicated a staff heard noises and found R3 laying on the floor between her dresser and an empty bed across the room with a blanket covering her face causing her voice to be muffled. R3 was unable to state what happened and was assessed for injuries and assisted off the floor using a hoyer.

A staff communication note dated May 1, 2022, at 1:36 p.m. indicated due to recurring falls staff were directed to keep R3's door open to to keep an eye on her and also implemented every two-hour checks.

A progress note dated May 2, 2022, at 10:40 a.m. indicated R3 had a recent decline in condition and was using a wheelchair due to being unsteady on her feet. The note indicated every two-hour safety checks had been implemented, in addition to keeping her door open.

A progress note dated May 3, 2022, at 4:26 p.m. indicated R3 was admitted to hospice for multiple recent falls and advanced Alzheimer's Disease with recent decline. The note indicated R3 required 1 staff assistance with pivots and transfers and was non ambulatory.

A progress note dated May 5, 2022, at 10:25 a.m. indicated R3 was found on the floor underneath her bed supine with pillows and blankets and was unable to state what happened. R3 had complaints of right-side pain since her previous fall prior to hospice admission.

A progress note dated May 6, 2022, at 8:54 a.m. indicated R3 had an X-ray completed with a fracture of her posterior lateral aspect of the right 11th rib.

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	30736	A. BUILDING: _____ B. WING _____	06/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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03000	Continued From page 16 On June 13, 2022, at 2:42 p.m. Registered Nurse (RN)-D stated a report MAARC report should have been filed and an investigation completed on both R3's incidents and investigations completed. RN-D stated as soon being made aware of potential maltreatment concerns an investigation should have been done and a report filed to MAARC within 24 hours of being made aware. RN-D verified no investigation was completed and no report to MAARC was made. The facility policy and procedure titled Vulnerable Adult Maltreatment Policy dated November 8, 2021, indicated if the incident appeared to be suspected abuse, neglect, or exploitation it would be reported to MAARC immediately, but no later than 24 hours from being made aware. An internal investigation would be completed. The policy included a document titled "VA Report Decision Tree" to guide staff if an incident was reportable or not. The decision tree indicated incidents resulting in harm that produce pain, injury, distress, or caused an unexplained injury should be reported. TIME PERIOD FOR CORRECTION: Seven (7) Days	03000		

Minnesota Department of Health

PO Box 64495
St Paul, Minnesota
651-201-4500

Type: Full
Date: *06/13/22*
Time: 11:00:21
Report: 1008221029

Food and Beverage Establishment Inspection Report

Location:
Psc Of Alexandria Llc
812 Mckay Avenue South
Alexandria, MN56308
Douglas County, 21

Establishment Info:
ID #: 0038935
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3207638244
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.

4-200 Equipment Design and Construction

4-204.115 ** Priority 2 **

MN Rule 4626.0635 Provide a temperature measuring device in the warewashing machine that indicates the temperature of the water in the wash tank, rinse tank, and the water that enters the sanitizing final rinse manifold or the chemical sanitizing solution tank.

PROVIDE A TEMPERATURE MEASURING DEVICE IN THE UNDERCOUNTER DISH MACHINE.

Comply By: 06/15/22

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

AT LEAST ONE EMPLOYEE OF THIS ESTABLISHMENT NEEDS TO HAVE A CURRENT CERTIFIED FOOD PROTECTION MANAGER CERTIFICATE.

Comply By: 06/27/22

4-200 Equipment Design and Construction

4-201.11GMN

MN Rule 4626.0506G Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

Serving kitchen that has domestic appliances must stop storing TCS (Time/Temperature food for safety control) food for more than 24 hours. If stored for more than 24 hours the items need to be discarded.

Comply By: 06/13/22

Food and Equipment Temperatures

Type: Full
Date: *06/13/22*
Time: 11:00:21
Report: 1008221029
Psc Of Alexandria Llc

Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: FRUIT CUP - NORTH KITCHEN
Violation Issued: No

Process/Item: Cold Holding
Temperature: 37 Degrees Fahrenheit - Location: BANANA CREAM PIE - SOUTH KITCHEN
Violation Issued: No

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

THINGS TO REMEMBER:

1 THE CERTIFIED FOOD PROTECTION MANAGER SHOULD BE ROUTINELY CONDUCTING SELF INSPECTIONS TO ENSURE THAT EMPLOYEES ARE FOLLOWING PROPER FOOD HANDLING PRACTICE.

2 EDUCATE EMPLOYEES ON THE IMPORTANCE OF REPORTING TO MANAGEMENT ANY ILLNESS THEY HAVE OR HAVE HAD RECENTLY. MANAGEMENT SHOULD EXCLUDE ANY WORKERS ILL WITH VOMITING OR DIARRHEA FROM HANDLING FOOD, AND THEY SHOULD KEEP AN UP TO DATE EMPLOYEE ILLNESS LOG.

3 THERE SHOULD BE A PERSON IN CHARGE A THE ESTABLISHMENT DURING ALL HOURS OF OPERATION. THIS PERSON SHOULD ENSURE THAT EMPLOYEES ARE PRACTICING GOOD HAND WASHING PROCEDURES, INCLUDING BEING KNOWLEDGEABLE ABOUT WHEN HAND WASHING SHOULD BE DONE AND HOW TO PROPERLY WASH HANDS.

4. EMPLOYEES SHOULD USE SPATULA, TONGS, DELI TISSUE, GLOVES OR SOME OTHER APPROVED MEANS TO PREVENT ANY DIRECT BARE HAND CONTACT WITH READY TO EAT FOODS.

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 1008221029 of 06/13/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Signed: Report Emailed
Establishment Representative

Signed: Inspector ID# 1088

Public Health Sanitarian 3
Fergus Falls District Office
651-201-4500
health.foodlodging@state.mn.us

Report #: 1008221029

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
PO Box 64495
St Paul, Minnesota

No. of RF/PHI Categories Out	1	**Date**	06/13/22
No. of Repeat RF/PHI Categories Out	0	**Time In**	11:00:21
Legal Authority MN Rules Chapter 4626		**Time Out**	

Psc Of Alexandria Llc	**Address** 812 Mckay Avenue South	**City/State** Alexandria, MN	**Zip Code** 56308	**Telephone** 3207638244
License/Permit # 0038935	**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		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) Report Emailed **Date:** 06/15/22

Inspector (Signature) Inspector ID# 1008