Electronically Delivered

September 16, 2022

Administrator
SCMC Courage Cottage
409 East 1st Street
Morris, MN 56267

RE: Project Number(s) SL21272015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on August 31, 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, the following fines are assessed pursuant to this evaluation:

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00

The total amount you are assessed is $500.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

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

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in 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 Chenze, Interim Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jessica.chenze@state.mn.us
Telephone: 218-332-5175 | Fax: 218-332-5196

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21272	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCMC COURAGE COTTAGE	409 EAST 1ST STREET MORRIS, MN 56267

(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#21272015 On August 29, 2022, through August 31, 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 was five (5) residents, all of whom received services under the provider's Assisted Living 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 Home Care/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 144A.474 subd. 11 (b) (1) (2) -or- 144G.31 subd. 1, 2 and 3.	

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0 000	Continued From page 4	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	

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0 000	Continued From page 5	0 000	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. 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	

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0 000	Continued From page 6	0 000	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.	
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's residents, staff, and visitors.	0 110		

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0 110	Continued From page 7 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on August 22, 2022, at approximately 1:45 p.m., licensed assisted living director/registered nurse (LALD/RN)-A identified herself as the LALD for the facility. LALD/RN-A obtained an assisted living director license on June 2, 2021. On August 22, 2022, at 3:58 p.m., the Board of Executives for Long-Term Services and Support (BELTSS) website, indicated LALD/RN-A held a current assisted living director license. The BELTSS website did not indicate LALD/RN-A was listed as the Director of Record for the licensee. On August 22, 2022, at 3:58 p.m., immediately after BELTSS website was reviewed with LALD/RN-A. LALD/RN-A confirmed she was not listed as the Director of Record for licensee. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		

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0 510	Continued From page 8	0 510		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure infection control standards were followed for two of two unlicensed personnel (ULP-B, ULP-E) during personal cares, blood glucose monitoring and medication administration for R1. In addition, licensee failed to establish and maintain an effective infection control program that complied with accepted health care, medical and nursing standards for infection control related to COVID-19, consistent with current guidelines from the Centers for Disease Control and Prevention (CDC) related to wearing appropriate PPE (personal protective equipment). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all	0 510		

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0 510	Continued From page 9 of the residents). The findings include: HAND HYGIENE On August 30, 2022, at 7:06 a.m., the surveyor observed ULP-E and ULP-B assist R1 with morning personal cares. With gloved hands ULP-E cleaned R1's perineum [area between anus and vulva] with pre-moistened wipes. The first three wipes used were soiled, the fourth wipe was not. ULP-B and ULP-E applied a new brief to R1 and then assisted R1 into a dress. R1's bed was lowered and a lift sling [a sling placed under a person which is attached to an assisted device to assist a person with transfers] under R1 by ULP- B and ULP-E. ULP-E did not complete hand hygiene at any time during this part of the surveyor's observation. On August 30, 2022, at approximately 7:45 a.m., the surveyor observed ULP-B with gloved hands clean a finger on R1's hand with an alcohol pad and use a lancet (small needle used to poke the skin [usually on a finger] to get a small drop of blood). ULP-B wiped R1's finger where the blood sample had been taken with a tissue, removed gloves and threw them away in a trash container. ULP-B cleaned the blood glucose (sugar) meter (device that will test blood sample to determine blood glucose level) with a disinfecting wipe, put on a new pair of gloves, and removed R1's medications from a seven-day medication planner. ULP-B removed a binder from a cabinet which contained R1's medication administration record (MAR) and a pill crusher from a cabinet. ULP-B used the pill crushed to prepare R1's medications. ULP-B documented R1's medication administration in the MAR and put the binder	0 510		

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0 510	Continued From page 10	0 510		

back into the cabinet. ULP-B mixed the crushed medications into a container of applesauce and fed the container to R1. ULP-B did not complete hand hygiene at any point during the surveyor's observation.

On August 30, 2022, at 8:57 a.m., licensed assisted living director/registered nurse (LALD/RN)-A verified staff hand hygiene should be done "all the time", if dirty, when gloves are taken off and re-gloving occurs.

On August 30, 2022, at 10:13 a.m., regarding hand hygiene ULP-B stated, "if I touch mask or something or when done with someone." When interviewed by surveyor, if hand hygiene should be performed after medication administration, ULP-B replied, "yeah, I am sorry, and after laundry and trash out, or sanitizer used."

On August 30, 2022, at 10:15 a.m., regarding hand hygiene ULP-E stated hand hygiene should be done "after wipe butt", or "when I feel like they [hands] are dirty".

The licensee's Infection Control Precautions policy revised March 23, 2021, hands should be washed before and after patient contact, before and after gloving. In addition, this policy indicated PPE must be appropriate for the type of Healthcare Worker (HCW)-patient encounter which may include: gloves, gowns, masks and protective eye wear such as goggles or face shields.

PERSONAL PROTECTIVE EQUIPMENT (PPE)

The Minnesota Department of Health (MDH) guidance titled, "COVID-19 [personal protective equipment (PPE)] and Source Control Grids - for

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0 510	Continued From page 11 congregate care settings, by community transmission level", dated April 7, 2022, indicated during "substantial" or "high" levels of community transmission (based on the Centers for Disease Control and Prevention (CDC) online data tracking system), caregivers must wear a face mask (source control) and eye protection while working with clients without suspected or confirmed SARS-CoV-2 infection. On August 30, 2022, at 6:30 a.m., the surveyor observed ULP-D apply a transfer belt (a device put on a person who has mobility issues, by a caregiver prior to the caregiver moving the person) around R2's upper body and assist him to the bathroom. ULP- D was wearing a surgical grade mask, but no eye protection. On August 30, 2022, at 8:41 a.m., LALD/RN-A verified staff were not currently wearing eye protection. LALD/RN-A stated RN-C checked it [current level] last week and told LALD/RN-A they were "in the yellow." LALD/RN-A added they (RNs) "switch" who checks the level every week depending on call. LALD/RN-A reviewed with the surveyor the facility's county transmission level on the computer. The CDC site indicated the transmission rate was high. LALD/RN-A accepted the offer of the surveyor to send the CDC website to LALD/RN-A's email address. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 510		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment	0 550		

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0 550	Continued From page 12 All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional 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. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required information related to the grievance procedure, as well as information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). This had the potential to affect all current residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 29, 2022, at approximately 2:15 p.m., the surveyor toured the facility with licensed assisted living director/registered nurse (LALD/RN)-A. The main entrance and/or common areas lacked the required posting for the	0 550		

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SCMC COURAGE COTTAGE	409 EAST 1ST STREET MORRIS, MN 56267

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0 550	Continued From page 13 grievance procedure to include the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. On August 29, 2022, at 2:24 p.m., LALD/RN-A verified the required grievance procedure content had not been posted. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies 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 tenant 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	0 680		

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0 680	Continued From page 14 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 a written emergency preparedness plan (EEP) with all the required content. In addition, they failed to review the missing person policy quarterly. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on August 29, 2022, at approximately 2:15 p.m., the surveyor asked for the licensee's emergency preparedness plan (EPP) which was provided to and later reviewed by the surveyor. On August 29, 2022, at approximately 2:25 p.m., a facility tour was conducted with licensed assisted living director/registered nurse (LALD/RN)-A. There was no observed signage posted or information regarding the licensee's EPP in the common areas of the facility. However, LALD/RN-A pointed to a metal ring hanging up in the nursing/staff station (a room	0 680		

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0 680	Continued From page 15 that was off the common area, close to the kitchen/dining area) that had several emergency policies attached, each enclosed in separate protective covering. On August 29, 2022, at approximately 3:00 p.m., LALD/RN-A made a phone call and the facilities EPP plan was brought to the surveyor. On August 29, 2022, at 3:08 p.m., LALD/ RN-A confirmed the EEP was not accessible to all. On August 29, 2022, at 3:13 p.m., LALD/RN-A confirmed there was no evidence the missing person policy was reviewed quarterly. LALD/RN-A added she had reviewed the missing person policy in May and "I was going to do it at the staff meeting but I canceled that since you are here." On August 30, 2022, at 10:04 a.m., the facility's EEP risk assessment was found upside down on a workspace the surveyor was using, dated January 17, 2022. The licensee's Emergency Operations Plan policy, dated revised May 28, 2021, noted the facility's plan was to provide a program that ensures mitigation, preparation, response, and recovery to disasters to emergencies affecting the environment of care. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
01420 SS=F	144G.62 Subd. 2 Delegation of assisted living services	01420		

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01420	Continued From page 16 (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If an unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the licensee failed to ensure the registered nurse (RN)-C provided training for unlicensed personnel (ULP)-B and all other staff on the delegated task of body alarm use and Broda chair [a wheelchair offering tilt-n-space positioning with a seating system which prevents skin breakdown through reducing heat and moisture]. 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: ULP-B was hired September 21, 2021, to provide	01420		

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01420	Continued From page 17 direct care services to the licensee's residents. On August 30, 2022, at 7:06 a.m., the surveyor observed ULP-B and ULP-E assist R1 with morning personal cares. R1 had a body alarm (personal body alarm with a pull string that when the string is pulled away from the unit an alarm sounds) attached to her clothing which was unfastened when ULPs assisted R1. ULP-B and ULP-E applied a new brief to R1 and then assisted R1 into a dress. R1's bed was lowered and a lift sling [a sling placed under a person which is attached to an assisted device to assist a person with transfers] under R1 by ULP- B and ULP-E. R1 was transferred into a Broda chair. R1's Care Plan and Weekly Services Delivery Record dated August 26, 2022, included clip alarm while in bed and in Broda chair. ULP-B's record lacked documentation to indicate ULP-B had received training and demonstrated competency for the body alarm or for the Broda chair. On August 30, 2022, at 10:47 a.m., licensed assisted living director/registered nurse (LALD/RN)-A verified she had not trained any of staff on the use of a Broda chair. On August 31, 2022, at approximately 8:45 a.m., LALD/RN-A confirmed she had not trained any of the staff on the use of body alarms. The licensee's Delegation of Nursing Tasks policy revised August 3, 3021, indicated the RN would verify the ULP was trained and competent and was instructed in the proper methods to perform the task with respect to the specific client; if the ULP was not trained the RN would provide	01420		

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01420	Continued From page 18 training in-person, verbally, or through other acceptable methods. The RN or other appropriately licensed staff would document any ULP training and/or competencies. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01420		
01710 SS=D	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure the registered nurse (RN) completed reassessment with change of condition in medication administration status for one of one resident (R2) with records reviewed. 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).	01710		

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01710	Continued From page 19 The findings include: On August 30, 2022, at 6:30 a.m., the surveyor observed a small plastic bag containing an unopened container of Genteal Tears [fast relief from moderate irritation and discomfort caused by dry eye] on a side table in R2's room. R2's diagnoses included chronic obstructive pulmonary diseases (COPD-chronic obstruction of lung airflow that interferes with normal breathing), hypovolemia (a decreased volume of circulating blood in the body), hypertension (HTN-high blood pressure) and congestive heart failure (CHF-heart is unable to properly circulate blood). R2's prescriber's order dated August 10, 2021, included "artificial tears as directed. Resident make (sic) keep in room, family provides." R2's Assessment of Need For Medication Management Services, dated May 3, 2022, and authenticated by RN-C, included: -resident can state name of medication: needs assistance -resident know what each med is for: needs assistance; -can read bottle for name & dosage: needs assistance; -knows when to take each med: needs assistance; -remembers to take each med on time: needs assistance; -able to report any symptoms: needs assistance; -able to open containers: needs assistance; -able to administer eye drops: needs assistance. Problem areas identified: vision loss: macular degeneration.	01710		

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01710	Continued From page 20 Services Needed Based on Assessment Individual Medication Management Plan (IMMP): -medication set-ups; -administration of medications; -storing and securing medications; -monitoring of medications for effectiveness side effects, pain management, etc; -coordinating refills; -handling and implementing changes to prescriptions; and -communicating with the prescriber (s) and pharmacy. On August 30, 2022, at 1:35 p.m., assisted living director/registered nurse (LALD/RN)-A confirmed R2's medication assessment had not been updated as required. The licensee's Initial and Ongoing Assessments policy revised August 5, 2021, indicated the RN would re-assess each resident on an on-going basis and would reassess if the resident had a change in condition to include: Evaluation of the resident's medication management services and the resident's medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation	01760		

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01760	Continued From page 21 must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the steps of the medication administration process was followed for one of two employees, unlicensed personnel (ULP)-B observed during administering medications. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: Medication for R1 were documented by ULP-B as being administered prior to the medications being administered. R1's diagnoses included dementia, diabetes and hypertension (HTN-high blood pressure). R1's Medication Administration Record (MAR) dated August 1, 2022, through August 30, 2022,	01760		

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01760	Continued From page 22 indicated R1 received Tylenol Extra Strength 1000 milligrams (mg), aspirin 162 mg., Seroquel (atypical antipsychotic) 25 mg., lisinopril (high blood pressure) 20 mg at 8:00 a.m. On August 30, 2022, at 7:45 a.m., the surveyor observed ULP-B conduct a medication pass for R1 and the following was observed: -ULP-B removed a seven-day medication planner from a locked cabinet -ULP-B checked R1's MAR and removed two medications for a seven-day pill planer (dosage box) and put them into a pill crusher [container that uses a twisting motion to crush/grind medications] and signed them out in the medication administration record (MAR) -ULP-B checked the MAR removed two more medications from R1's dosage box and put them into the pill crusher and signed it out in the MAR -ULP-B checked the MAR removed one medication from R1's dosage box and put it into a pill crusher and signed it out in the MAR. On August 30, 2022, at 9:03 a.m., licensed assisted living director/registered nurse (LALD/RN)-A verified staff are to document on MAR after medication is given, not prior. LALD/RN-A added afternoon staff are working this morning due to staff call ins. The licensee's Administration of Medications and Treatments policy revised August 5, 2021, indicated documentation, after assistance with self-administration of medications or medication, treatment and therapy administration, consistent with our agency's procedures for documenting the MAR. No further information was provided.	01760		

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01760	Continued From page 23 TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled;	01790		

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01790	Continued From page 24 (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure one of one unlicensed personnel (ULP-B) and all other ULPs were trained and had demonstrated competency for the procedure of medications for residents having unplanned time away. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems	01790		

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01790	Continued From page 25 are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on August 29, 2022, at approximately 1:50 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated the licensee provided medication management services to the residents. TRAINING AND COMPETENCY EVALUATIONS ULP-B was hired on September 21, 2021, to provide direct care for the licensee's residents which included medication administration. ULP-B's employee record lacked evidence to indicate she had been trained and had demonstrated competency to provide medications to residents for unplanned times away from home. On August 30, 2022, at 10:49 a.m., LALD/RN-A questioned, "we [facility] has to do that [medications for unplanned time away]?" LALD/RN-A added "our people here are good about taking them out not over medication time". LALD/RN added Educare [on-line training system] does their [facility] medication training. LALD/RN was not able to produce what training had been done on Educare for medications for unplanned time away from home On August 30, 2022, at 1:45 p.m., the facility's policy for unplanned time away was reviewed with LALD/RN-A. LALD/RN confirmed she was unaware of the agency's package of forms	01790		

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01790	Continued From page 26	01790		

needed to accompany the medications. LALD/RN stated she would change the facility's policy. In addition, LALD/RN-A confirmed there was no evidence of ULP training or demonstration of competency to provide medications to residents for unplanned times away from home.

The licensee's Medications to be Given When Time Away From Home policy revised August 3, 2021, indicated the agency would provide the necessary medications, education, instructions and support to meet the client's medication needs when they are away from home if the agency provides assistance with self-administration of medication, administration or storage of medications. Only the RN has trained in competency to place medications prepared by a pharmacist in the appropriate container for an unplanned leave of absence not to exceed 7 days of medications. Procedure included:
-contact the RN on-call upon notification by client or family of pans to be absent during medication administration ties to seek directions. (Special instructions may include the need for the RN to talk to the client or client's representative, instructions for storage, or the controlled substances);
-Review the medication administration record to determine the medications that will need to be sent with the client;
-obtain medications that will be needed for planned LOA;
-obtain the agency 'package of forms needed to accompany the medication This will include a current copy of the medications to be taken during the LOA in a manner the client or client's representative can understand;
-document the medications given in format required by agency by medication, dose, quantity, and name of individual to whom the medication

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01790	Continued From page 27 was given; -request signature from client and/or client's representative signature to attest receipt of information on agency specific form; -upon return the assisted living facility, obtain unused or refused medications form the client or client's representative; -document the name and quantity of medication returned upon agency approved form or electronic medication record (EMR); -if medications are given to unlicensed personnel, unlicensed staff will notify the RN of the medications returned. RN will instruct unlicensed personnel on storage and security of unused medications and any other additional instructions. No returned medications would be administered without RN instructions; and -if there are any questions of medications or concerns on the LOA procedure, the unlicensed staff will call the on-call RN for further instructions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by:	01890		

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	21272	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCMC COURAGE COTTAGE	409 EAST 1ST STREET MORRIS, MN 56267

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01890	Continued From page 28 Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription label with legible information including the expiration date for time sensitive medications for two of five residents (R3, R4). In addition, the licensee failed to monitor for expired medications for one of five residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 29, 2022, at approximately 2:15 p.m., the surveyor toured the facility with licensed assisted living director/registered nurse (LALD/RN)-A, including a review of the locked medication cupboard. LALD/RN-A and RN-C observed and confirmed the following: DATING OF TIME SENSITIVE MEDICATIONS R3 R3'S opened Refresh Tears (lubricating eye drops) lacked a label to indicate the date the eye drop solution was opened and when the solution would expire. R4 R4's opened Refresh Tears lacked a label to indicate the date the eye drop solution was opened and when the solution would expire.	01890		

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SCMC COURAGE COTTAGE	409 EAST 1ST STREET MORRIS, MN 56267

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01890	Continued From page 29 On August 29, 2022, at 2:31 p.m., RN-C verified it was not their [facility] practice to date eye drops and nasal sprays, RN-C added, they (facility) date insulin. The manufacturer's instructions for Refresh Tears dated March 2018, directed to discard the eye drop solution 90 days after opening. EXPIRED MEDICATION R3 Triamcinolone Acetonide (used to help relieve redness, itching, swelling or other discomfort caused by skin conditions) 0.1% expired April 29, 2022. August 29, 2022, at 2:25 p.m., directly following the above observation LALD/RN-A and RN-C stated all expired medications should be discarded. The licensee's medication storage policy was requested, but not provided. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility	01940		

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01940	Continued From page 30 must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to implement a treatment or therapy management plan according to prescriber's orders or one of one resident (R2) with records reviewed. 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	01940		

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01940	Continued From page 31 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's Care Plan and Weekly Delivery Record failed to follow prescriber's orders for oxygen administration. R2's diagnoses included chronic obstructive pulmonary diseases (COPD-chronic obstruction of lung airflow that interferes with normal breathing), hypovolemia (a decreased volume of circulating blood in the body), hypertension (HTN-high blood pressure) and congestive heart failure (CHF-heart is unable to properly circulate blood). R2's Care Plan and Weekly Services Delivery Record dated August 29, 2022, included oxygen 2 liters per nasal cannula at hours of sleep (HS), assist of 1, as needed, requested or if [in red] SP02 (a measure of the amount of oxygen affixed to hemoglobin [protein in red blood cells that carries oxygen] calls within the circulatory system) drops below 90% or becomes short of breath. R2's prescriber orders dated July 13, 2022, included the order for oxygen at 2 liters (L) via nasal cannula (a lightweight tube which on one end splits into two prongs which are placed in the nostrils to deliver supplemental oxygen) at night. Oxygen during the day at 2-3 L via nasal cannula for comfort or for saturation (sats) less than 90%. On August 30, 2022, at 6:30 a.m., the surveyor observed unlicensed personnel (ULP)-D apply a transfer belt (device to assist in transfers) around R2's body and assist R2 to the bathroom. ULP-D	01940		

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01940	Continued From page 32 then assisted R2 back to his bed and applied a nasal cannula under R2's nose. An oxygen concentrator (device concentrating the oxygen from a gas supply by selectively removing nitrogen to supply as oxygen enriched product gas stream) was on and set at 2 L of oxygen per minute. On August 30, 2022, at 1:41 p.m., licensed assisted living director/registered nurse (LALD/RN)-A and RN-C confirmed R 2's care plan failed to follow prescriber's orders as written for oxygen administration. RN-C added she did not want staff turning the oxygen up. The license's Training ULP for Medication, Treatment and Therapy policy revised August 17, 2021, indicated the RN would include the complete procedure in a resident record and the nurse's written procedures specific to the resident for the administration of any delegated tasks, this included procedures for administration of any over-the counter medications, PRN medications or dietary supplements, treatment and therapy, the facility has agreed to provide for the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
02310 SS=F	144G.91 Subd. 4 Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards.	02310		

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02310	Continued From page 33 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards with registered nurse (RN) for two of two resident (R2, R1) who utilized a body alarm (personal alarm with a pull string that is to be attached to a person, when the string is pulled from the unit an alarm sounds) with records reviewed. 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: R2 and R1's records lacked evidence that the RN completed an assessment prior to the placement of a body alarm. R2 R2's diagnoses included chronic obstructive pulmonary diseases (COPD-chronic obstruction of lung airflow that interferes with normal breathing), hypovolemia (a decreased volume of circulating blood in the body), hypertension (HTN-high blood pressure) and congestive heart failure (CHF-heart is unable to properly circulate blood) R2's Care Plan and Weekly Services Delivery Record dated August 29, 2022, included: -Safety: fall risk. Resident clip alarm while in bed;	02310		

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02310	Continued From page 34 and -Chair alarm while in chair. On August 30, 2022, at 6:30 a.m., the surveyor observed unlicensed personnel (ULP)-D respond to an alarm. ULP-D went to R2's room and turned off an alarm and remove a clip that was attached to R2 (body alarm). R2 applied a transfer belt (device to assist in transfers around R2's body) and assist R2 to the bathroom. ULP-D then assisted R2 back to his bed and applied a nasal cannula under R2's nose. R1 R1's diagnoses included Alzheimer's dementia, diabetes and hypertension (HTN-high blood pressure). R1's Care Plan and Weekly Services Delivery Record dated August 29, 2021, included: -Safety: clip alarm while in bed. On August 30, 2022, at 7:06 a.m., the surveyor observed ULP-B and ULP-E assist R1 with morning personal cares. R1 had a body alarm (personal body alarm with a pull string that when the string is pulled away from the unit an alarm sounds) attached to her sleep wear which was unfastened when ULPs assisted R1. ULP-B and ULP-E applied a new brief to R1 and then assisted R1 into a dress. On August 31, 2022, at approximately 8:40 a.m., assisted living director/registered nurse (LALD/RN)-A confirmed assessments for body alarms had not been done for R1, R2 and two other residents who use body alarms. LALD/-A stated, they [residents] are all fall risks. LALD/RN-A added they have one resident who does not use a body alarm.	02310		

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02310	Continued From page 35 The licensee's Delegation of Nursing Tasks policy revised August 3, 2022, indicated the RN would complete an assessment of the resident and determine need for nursing services. The RN would develop a care plan for providing the services according to the resident's needs and preferences and the RN would verify the ULP was trained and competent and was instructed in the proper methods to perform the task with respect to the specific client. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		
02410 SS=E	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or where clearly inadvisable or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan.	02410		

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02410	Continued From page 36 Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure privacy was maintained for one of one resident (R1) observed during blood glucose monitoring and for one of one resident (R3) with eye drop and nasal medication administration. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1's blood glucose (sugar) monitoring was conducted while seated in the occupied open dining room area by unlicensed personnel (ULP)-B. R1's diagnoses included Alzheimer's dementia, diabetes and hypertension (HTN-high blood pressure). R1's Care Plan and Weekly Services Delivery	02410		

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02410	Continued From page 37 Record dated August 29, 2021, included: -blood sugar (BS) checks four times a day with meals and bedtime; -Blood Glucose (BG) When To Notify Nurse (in red); -Fasting BG less than 75 Give 1 cup Milk, or ½ cup juice, or 1 tablespoon honey or 3-4 glucose tablets Recheck BS15 minutes after snack; -Any BG less than 100; -Any BS over 300; -if bedtime BG is less than 120 give snack such as Glucerna or toast with peanut butter On August 30, 2022, at 7:41 a.m., R1 was seated at the dining room table in the open dining room/kitchen area. R2 was also seated at this table. The surveyor observed ULP-B with gloved hands clean a finger on R1's hand with an alcohol pad and use a lancet (small needle used to poke the skin [usually on a finger] to get a small drop of blood). R1 said "ouch" when the lancet was inserted. The blood sample was put onto a BS testing strip which had been inserted into the BS meter (device that will test blood sample to determine blood glucose level). ULP-B asked R1 if she could take her BS, but ULP-B did not encourage, offer, or attempt to direct R1 to a private area to test BS. ULP-B then called out R1's BS results "87, get her (R1) some juice". RN-C was working in the kitchen at that time. R3 R3's eye and nasal medications were administered in the occupied open dining room area by licensed assisted living director/registered nurse (LALD/RN)-A R3's diagnoses included dementia, HTN, dry eyes, allergies, constipation and gastroesophageal reflux disease (GERD)	02410		

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02410	Continued From page 38 [stomach contents and acid rise up into the esophagus]. R3's Service Plan dated October 29, 2020, included medication administration as ordered daily and as needed. On August 30, 2022, at 8:15 a.m., R3 was seated at the dining room table in the open dining area with R1 and R2. The surveyor observed LALD/RN-A bring a bottle of eye drop medication and nasal medication to R3. LALD/ RN-A administered eye medication into R3's eyes and gave R3 the nasal medication. R3 administered nasal medication to himself at the dining room table. LALD/RN-A did not encourage, offer, or attempt to direct R3 to a private area to administer eye or nasal medication. On August 30, 2022, at 8:57 a.m., LALD/RN-A and RN-C were interviewed by the surveyor regarding R-3's medications given at the occupied table. LALD/RN-A stated R3 took his medications at home independently, so she did not see an issue with him talking medications at the table. RN-C added R3 administrated his nasal medication himself. On August 30, 2022, at 9:03 a.m., RN-C was interviewed by the surveyor regarding taking R1's BS at the occupied table. RN-C replied normally BS is taken in room before R1 was brought out of her room, however RN-C added, different staff are working this am, evening staff (PM), because of staff call ins. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02410		

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MN Department of Health
Food, Pools, and Lodging Services
PO Box 64975
St. Paul, MN 55164-0975
218-332-5150

Type: Full
Date: *08/30/22*
Time: 14:17:35
Report: 7935221226

Food and Beverage Establishment Inspection Report

Location:
Dba Scmc Courage Cottage
409 East 1st Street
Morris, MN56267
Stevens County, 75

Establishment Info:
ID #: 0038079
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3205855134
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.

No NEW orders were issued during this inspection.

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: Fridge
Violation Issued: No

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

Things to Remember:

1. The Certified Food Manager should be routinely conducting self inspections to ensure that employees are following proper food handling practices.

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 at 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.

Type: Full
Date: *08/30/22*
Time: 14:17:35
Report: 7935221226
Dba Scmc Courage Cottage

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the MN Department of Health inspection report number 7935221226 of 08/30/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Signed:_____ Signed: 7935

Establishment Representative

7935

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