Electronically Delivered

September 28, 2023

Licensee
The Country Villa
520 1st Street Northeast
Sartell, MN 56377

RE: Project Number(s) SL20559015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 31, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

The MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5), the MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
The MDH may impose a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The MDH also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

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

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

The correction order documentation should include the following:

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

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

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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

If you have any questions, please contact me.

Sincerely,

Kelly Thorson

Kelly Thorson, Supervisor
State Evaluation Team
Email: kelly.thorson@state.mn.us
Telephone: 651-431-5000 Fax: 1-866-890-9290

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20559	A. BUILDING: _____ B. WING _____	08/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COUNTRY VILLA	520 1ST STREET NE SARTELL, MN 56377

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL20559015-0 On August 28, 2023, through August 31, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 248 residents, 71 of whom received services under the provider's Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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.	
0 430 SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to	0 430		

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0 430	Continued From page 1 prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the uniform checklist disclosure of services (UDALSA) accurately reflected services provided by the licensee. This had the potential to affect all residents requesting an as needed medication or residents with diabetes during the night shift. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include:	0 430		

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0 430	Continued From page 2 The licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA), last updated January 1, 2023, indicated on page 2, under general information that unlicensed staff were in the building and available to respond to resident requests 24/7 (24 hours per day/7 days per week), with two unlicensed direct care staff typically scheduled on the night shift. On page 4, under Medication Management Services Available, it indicated medication administration was available by licensed or unlicensed personnel, but did not indicate it wasn't always available at night. On page 6, under Treatment & Therapies Available, it was indicated that the facility was prepared to provide diabetic care with blood glucose monitoring, but did not indicate it wasn't always available at night. On August 31, 2023, at 5:53 a.m., unlicensed personnel (ULP)-I stated he typically worked the night shift, and said sometimes there was not anyone on the night shift trained to administer medications. ULP-I stated if a resident asked for medications at night, he would call the on-call registered nurse (RN). On August 31, 2023, at 6:15 a.m., ULP-J stated she typically worked the night shift, and stated a lot of the nights there was a person available to administer medications, but if there was not, she would call the on-call RN. On August 31, 2023, at 6:20 a.m., ULP-K stated she worked the overnight shift and unlicensed staff working the night shift were not trained to give medications or perform blood glucose testing. When the surveyor asked what she would do if a resident requested a medication or was diabetic and did not feel well during the night,	0 430		

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0 430	Continued From page 3 ULP-K stated she would call the campus nurse, and if there was no nurse onsite, she would call the on-call RN. ULP-K stated the nurses say there was nothing they could do unless the resident wanted to go to the hospital. On August 31, 2023, at 10:48 a.m., clinical nurse supervisor (CNS)-A stated unlicensed staff working the night shift did not receive medication administration training, and unlicensed staff that were never going to give medications, did not receive training on blood glucose monitoring. On August 31, 2023, at 2:41 p.m., CNS-A stated if a diabetic resident was showing signs or symptoms of blood sugar being out of range, and the nurse or trained medication aide was not available on the night shift, unlicensed staff would call 911. CNS-A could not explain why the UDALSA indicated they provided medication administration and diabetic care with blood glucose monitoring and did not indicate that it was not available at all times. The licensee's Uniform Disclosure of Assisted Living Services & Amenities (UDALSA) policy, dated November 14, 2022, indicated the facility UDALSA would disclose the amenities permitted under the facility's license, identifying all services and amenities the facility offers to provide and does not provide. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 430		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements	0 470		

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0 470	Continued From page 4 (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure sufficient staffing to meet the needs of 37 residents who received medication administration services and 6 residents who received blood glucose monitoring services. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 470		

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0 470	Continued From page 5 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee lacked sufficient staffing to meet the residents' needs on a 24-hour basis, based on resident needs and the Uniform Disclosure of Assisted Living Services and Amenities (UDALSA). During the entrance conference on August 28, 2023, at 10:50 a.m., clinical nurse supervisor (CNS)-A stated the licensee provided medication administration services to residents at the facility. In addition, CNS-A stated the staffing for the night shift was from 10:00 p.m. through 6:30 a.m., with a total of three staff, which may include a licensed practical nurse (LPN), but not always. The licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA), last updated January 1, 2023, indicated on page 2, under general information that unlicensed staff were in the building and available to respond to resident requests 24/7 (24 hours per day/7 days per week), with two unlicensed direct care staff typically scheduled on the night shift. On page 4, under Medication Management Services Available, it indicated medication administration was available by licensed or unlicensed personnel, but did not indicate it wasn't always available at night. On page 6, under Treatment & Therapies Available, it was indicated that the facility was prepared to provide diabetic care with	0 470		

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0 470	Continued From page 6 blood glucose monitoring, but did not indicate it wasn't always available at night. R7 R7's diagnoses included hypertension (high blood pressure), fracture of the radius in July 2023. R7's Service Plan Agreement dated August 7, 2023, noted services including assistance with ambulation, physical assist of one staff with transferring, and medication administration. R7's Master Assessments dated August 7, 2023, and August 14, 2023, indicated R7 had pain complaints, and received daily pain management including as needed hydrocodone (a narcotic pain reliever) and Tylenol. R7's August 2023 Medication Sheet listed hydrocodone-acetaminophen 10-325 milligrams take one tablet by mouth three times daily (morning, noon, and before bedtime) as needed. It was noted as given 21 times through August 30, 2023, with the following during the night shift hours: - August 14, 2023, at 03:39 for severe pain, - August 20, 2023, at 22:01 for severe pain, and - August 23, 2023, at 22:02 for severe pain. On August 31, 2023, at 10:50 a.m., R7 stated she sleeps at night, and added she does not ask for medications at night because there isn't anyone available to give medications. On August 30, 2023, at 3:15 p.m., RN-E stated sometimes there were nights with no medication trained staff working. RN-E also stated the facility had let all residents and families know they do not have anyone at nighttime for passing medications. RN-E stated overnight staff would	0 470		

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0 470	Continued From page 7 reach out to the on-call nurse if someone needed medication and the nurse would have to come back in to administer the as needed medication. On August 30, 2023, at 3:58 p.m., RN-H stated LPNs work overnights, but licensee cannot guarantee there will be an LPN working or they might be busy, so residents know they need to wait for someone if medications are needed. RN-H stated if there was not an LPN working and someone needed a medication the building staff would reach out to on-call nursing. RN-H stated if they were on call, they would contact the resident's family and let them know they needed to come in and administer a medication or send the resident to the emergency room. On August 31, 2023, at 5:53 a.m., unlicensed personnel (ULP)-I stated he typically worked the night shift, and said sometimes there was not anyone on the night shift trained to administer medications. ULP-I stated if a resident asked for medications at night, he would call the on-call registered nurse (RN). On August 31, 2023, at 6:15 a.m., ULP-J stated she typically worked the night shift, and stated a lot of the nights there was a person available to administer medications, but if there was not, she would call the on-call RN. On August 31, 2023, at 6:20 a.m., ULP-K stated she worked the overnight shift and unlicensed staff working the night shift were not trained to give medications or perform blood glucose testing. When the surveyor asked what she would do if a resident requested a medication or was diabetic and did not feel well during the night, ULP-K stated she would call the campus nurse, and if there was no nurse onsite, she would call	0 470		

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0 470	Continued From page 8 the on-call RN. ULP-K stated the nurses say there was nothing they could do unless the resident wanted to go to the hospital. On August 31, 2023, at 10:48 a.m., clinical nurse supervisor (CNS)-A stated unlicensed staff working the night shift did not receive medication administration training, and unlicensed staff that were never going to give medications, did not receive training on blood glucose monitoring. On August 31, 2023, at 2:41 p.m., CNS-A stated if a diabetic resident was showing signs or symptoms of blood sugar being out of range, and the nurse or trained medication aide was not available on the night shift, unlicensed staff would call 911. CNS-A could not explain why the UDALSA indicated they provided medication administration and diabetic care with blood glucose monitoring and did not indicate that it was not available at all times. On August 31, 2023, at 2:55 p.m., CNS-A stated if a resident wanted or needed an as needed medication during the night shift when a medication trained staff person was not available, or if a blood sugar testing was needed, the on-call nurse would come in. CNS-A added if a person was found unresponsive, staff would call 911. In addition, CNS-A stated the current schedule rotation of two weeks had on week one only two days without a medication trained staff on the night shift, and week two one day without. CNS-A stated they had postings out for the position, and the plan was to have someone available to pass medications every night shift. The licensee's Staffing Plan policy dated August 1, 2021, noted the RN had overall responsibility and accountability for the development of staffing	0 470		

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0 470	Continued From page 9 plans. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated August 28, 2023, for the specific Minnesota Food Code deficiencies.	0 480		

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0 480	Continued From page 10 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
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 establish and maintain an effective infection control program that complied with accepted health care, medical and nursing standards for infection control related to gloving and hand hygiene for one of two employees (licensed practical nurse (LPN)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 510		

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0 510	Continued From page 11 The findings include: On August 29, 2023, at 11:25 a.m., the surveyor observed LPN-C providing medication administration with R1 in his apartment. LPN-C donned (applied) gloves, wiped R1's right middle finger with an alcohol wipe, poked the finger with a lancet, wiped it, and placed a sample of blood on the test strip. LPN-C placed the lancet in the sharps container on the kitchen counter removed the gloves, typed the result into the iPad, closed the glucometer case, and went to place dorzolamide-timolol eye drops into R1's eyes after donning a glove on the left hand. LPN-C removed the glove and performed hand hygiene. On August 29, 2023, at 11:45 a.m., LPN-C stated she should have performed hand hygiene after completing the blood glucose test and removing the gloves. On August 29, 2023, at 12:10 p.m., clinical nurse supervisor (CNS)-A stated she would expect hand hygiene to be performed after completing a blood glucose test on a resident and after removing gloves. On August 30, 2023, at 7:12 a.m., the surveyor observed as LPN-C knocked on R2's door and used her keys to enter R2's apartment. Without performing hand hygiene, LPN-C prepared and administered oral medications to R2. LPN-C used a device that she held against R2's blood glucose sensor and stated R2's blood glucose was 175. LPN-C took R2's Humalog insulin from a basket located in the locked cabinet in R2's kitchen, placed a disposable needle onto the pen, dialed the insulin pen to two units stating she was priming the needle, and then referred to the	0 510		

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0 510	Continued From page 12 electronic medication sheet on her device and stated she needed to administer one (1) unit. LPN-C dialed the insulin pen to 1 unit, and without donning gloves, LPN-C wiped R2's skin with an alcohol pad and administered the insulin into R2's abdomen. With bare hands, LPN-C removed the disposable needle and threw into a sharps container. Without performing hand hygiene, LPN-C touched the basket, electronic device, cabinet, the door handle of R2's apartment door, the light switch, and closed the door behind her, as she reached into her pocket for her keys. Once in the hallway and without performing hand hygiene, LPN-C knocked on the apartment door across the hall, used her keys to unlock the door, and entered the apartment of another resident. On August 30, 2023, at 7:20 a.m., LPN-C stated having a surveyor following her made her nervous, but stated she should have performed hand hygiene before and after performing medication administration and insulin administration, and prior to leaving R2's apartment. On August 31, 2023, at 3:04 p.m., CNS-A stated the licensee's insulin policy did not specify gloves should be worn when giving insulin. CNS-A stated hand hygiene should have been performed after working with one resident, before moving to the next resident. The licensee's Insulin policy, dated January 13, 2023, included important tips to remember when "assisting residents with self-administered insulin," and directed to always wash hands before setting up medications and at any time during the process if hands became contaminated. The policy directed to review the	0 510		

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0 510	Continued From page 13 Medication Administration Record (MAR), complete glucose monitoring if needed, draw up or dial up the resident's insulin, confirm accuracy of dose with prescriber order, monitor the resident injecting the medication, instruct the resident to place the used syringe in the sharps container, and replace the medication in the appropriate container. The policy then directed, "Wash hands." The policy lacked direction when the staff were administering the insulin. The licensee's Hand Washing policy dated January 13, 2023, noted when conducting a procedure that required the use of gloves, proper hand hygiene should be completed before donning and after removing gloves. The licensee's Blood Sugar Testing - Single Equipment Use policy dated January 13, 2023, noted after completion of the procedure, staff were to remove the gloves and wash their hands. The Centers for Disease Control's (CDC), "CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings" dated November 29, 2022, under section 5a.1-2 reads: 1.) Require healthcare personnel to perform hand hygiene in accordance with Centers for Disease Control and Prevention (CDC) recommendations. 2.) Use an alcohol-based hand rub or wash with soap and water for the following clinical indications: a.) Immediately before touching a patient; b.) Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices; c.) Before moving from work on a soiled body site to a clean body site on the same patient; d.) After touching a patient or the patient's immediate environment;	0 510		

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0 510	Continued From page 14 e.) After contact with blood, body fluids or contaminated surfaces; and f.) Immediately after glove removal Under section 5d.1 reads: 1. Ensure proper selection and use of personal protective equipment (PPE) based on the nature of the patient interaction and potential for exposure to blood, body fluids and/or infectious material: a.) Wear gloves when it can be reasonably anticipated that contact with blood or other potentially infectious materials, mucous membranes, non-intact skin, potentially contaminated skin or contaminated equipment could occur. b.) Wear a gown that is appropriate to the task to protect skin and prevent soiling of clothing during procedures and activities that could cause contact with blood, body fluids, secretions, or excretions. c.) Use protective eyewear and a mask, or a face shield, to protect the mucous membranes of the eyes, nose and mouth during procedures and activities that could generate splashes or sprays of blood, body fluids, secretions and excretions. Select masks, goggles, face shields, and combinations of each according to the need anticipated by the task performed. d.) Remove and discard PPE, other than respirators, upon completing a task before leaving the patient's room or care area. If a respirator is used, it should be removed and discarded (or reprocessed if reusable) after leaving the patient room or care area and closing the door. e.) Do not use the same gown or pair of gloves for care of more than one patient. Remove and discard disposable gloves upon completion of a task or when soiled during the process of	0 510		

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0 510	Continued From page 15 care. f.) Do not wash gloves for the purpose of reuse. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 780 SS=D	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced	0 780		

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0 780	Continued From page 16 by: Based on observation and interview, the licensee failed to provide smoke alarms in all sleeping rooms. This deficient condition had the ability to affect some staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: On a facility tour on August 31, 2023, from approximately 10:00 a.m. and 1:15 p.m., with licensed assisted living director (LALD)-B and director of maintenance (DM)-G it was observed that there was no smoke alarm installed in the second bedroom of apartment 74. These deficient conditions were visually verified by LALD-B and DM-G accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
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	0 800		

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0 800	Continued From page 17 residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain 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. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On August 31, 2023, from approximately 10:00 a.m. and 1:15 p.m., with licensed assisted living director (LALD)-B and director of maintenance (DM)-G it was observed that the women's restroom on the main level in the senior apartments had signs of water damage on the ceiling. The ceiling tiles were stained brown in two locations. It was observed that the wall in the spa room had damage from heavy equipment running along the entire wall adjacent to the door from the entrance to the other side of the room. Spas are humid	0 800		

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0 800	Continued From page 18 environments and damage to the drywall can be a location where moisture penetrates the material and causes additional damage or mold growth. It was observed that the trash chute door on the second floor of the Waterford Building did not self-close and latch. All trash chute doors should close and latch completely to maintain the fire resistance integrity of the trash chute system. It was observed that the ceiling tile outside the mechanical room by apartment 2111 in the Waterford Building was heavily stained and sagging from possible water damage above. DM-G stated there was a plenum filter above that area which could be causing the staining. LALD-B and DM-G visually verified these deficient findings at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance	01760		

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01760	Continued From page 19 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 medications were administered per manufacturer instructions for one of one resident (R1) and failed to ensure medications were administered as prescribed for one of five residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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: MEDICATIONS NOT ADMINISTERED PER MANUFACTURER'S RECOMMENDATIONS: R1's diagnoses included acute pulmonary edema, chronic kidney disease, and type 2 diabetes mellitus. R1's Service Plan Agreement dated June 20, 2023, indicated R1 received assistance with showering, dressing, blood pressure monitoring, oral medications, blood sugar testing, and injections. R1's prescriber orders dated August 28, 2023, included Lantus Solostar inject 13 units subcutaneously (sq) every morning for type 2 diabetes mellitus, and Humalog (lispro) inject 2 units sq at lunch.	01760		

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01760	Continued From page 20 On August 29, 2023, at 11:25 a.m., the surveyor observed licensed practical nurse (LPN)-C administer insulin to R1 in his apartment. LPN-C dialed the Lantus Solostar pen to one, expressed the fluid, and dialed the pen to 13. LPN-C then dialed the lispro to two, expressed the liquid, and dialed the pen to 2 units. LPN-C went to R1, wiped his abdomen with an alcohol wipe, and administered the insulin. On August 29, 2023, at 11:45 a.m., LPN-C stated she had been trained a long time ago to administer the insulin with the pens. She stated it was a standard nursing practice when you first use the pen to get the air out, and after that if you visually saw air you would prime it, but if you don't see air in the pen in use, you do not need to prime it. LPN-C stated she would prime the pen by dialing the pen to 1 or 2, expressing the fluid out, and dialing the ordered amount. On August 29, 2023, at 12:10 p.m., clinical nurse supervisor (CNS)-A stated the insulin pens should be primed before each use by dialing to 2, pushing out the fluid, before dialing to the prescribed amount. The manufacturer's instructions for use of the lispro insulin, dated revised February 2020 noted the pen should be primed before each injection, removing air from the needle and cartridge by turning the dose knob to select 2 units, and holding the pen with the needle pointing up and tapping the holder to gently collect air bubbles at the top, and pushing the dose knob until it stops and 0 is seen in the dose window. The manufacturer's instructions for use of the Lantus Solostar pen dated revised May 2019	01760		

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01760	Continued From page 21 noted to perform a safety test before each injection by selecting a dose of 2 units, holding the pen with the needle pointing upwards, tap the reservoir so any air bubbles may rise towards the needle, and press the injection button all the way in. The licensee's Insulin policy dated January 13, 2023, lacked instructions on priming the insulin pen. MEDICATIONS NOT ADMINISTERED AS PRESCRIBED On August 30, 2023, at 7:12 a.m., the surveyor observed as LPN-C prepared and administered one oral medication to R2, checked R2's blood glucose and administered insulin. R2's diagnoses included essential hypertension (high blood pressure with no identifiable cause), diabetes, vitamin B deficiency, protein-calorie malnutrition, preglaucoma, major depressive disorder, incontinence, anxiety, back pain, tremor, intervertebral disc degeneration, and headaches. R2's Service Plan Agreement, dated April 28, 2023, indicated R2 received services including stand by assistance with bathing, daily blood pressure monitoring, medication administration, blood glucose monitoring four times daily, insulin administration four times daily, safety checks, housekeeping and laundry. R2's prescriber orders, signed August 16, 2023, included propranolol (used to treat heart	01760		

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01760	Continued From page 22 problems, help with anxiety and prevent migraines) 20 milligrams (mg) in the morning and in the evening. The order included, "HOLD FOR SBP [systolic blood pressure] < [less than]100 OR HR [heart rate] <60." R2's Medication Sheet, dated July 2023, and August 2023, directed propranolol 20 mg tablet, take one tablet in the morning and in the evening. Also included, "HOLD FOR SBP <100 OR HR <60;" however, the following was noted: - On July 2, 2023, at 10:30 a.m., R2's pulse was 56; however, staff initials indicated the medication was given; - On July 3, 2023, at 10:30 a.m., R2's pulse was 57; however, staff initials indicated the medication was given; - On July 26, 2023, at 10:30 a.m., R2's pulse was 57; however, staff initials indicated the medication was given; and - On August 13, 2023, at 10:30 a.m., R2's pulse was 54; however, staff initials indicated the medication was given. During an interview on August 30, 2023, at 3:41 p.m., registered nurse (RN)-E reviewed the Medication Sheet and stated the propranolol should have been given according to the prescriber's orders. On August 31, 2023, at 2:18 p.m., CNS-A stated staff should have followed the doctor's orders and held the propranolol for R2's heart rate of <60. The licensee's Documentation of Medication Services On The MAR (medication administration record) or eMAR (Electronic System) policy, dated January 13, 2023, directed staff would administer the medications according to the instructions on the MAR or eMAR.	01760		

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01760	Continued From page 23 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure up-to-date written or electronically treatment orders were maintained for one of three residents (R5). 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: R5 was admitted to the licensee on December 10, 2021, with diagnosis of hypertension, sleep	01970		

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01970	Continued From page 24 disorder, and anxiety disorder. R5's Service Plan signed on July 7, 2023, indicated R5 received services for medication management and oxygen safety. R5's medication administration record (MAR) for August 2023, indicated oxygen to be applied at one liter at bedtime for comfort for anxiety disorder, unspecified. R5's medical record contained an order from March 28, 2022, that indicated R5 would use a home oxygen concentrator at 1 liter per nasal cannula at night for nocturnal hypoxia for a duration of six months. Licensee had one progress note from the physician stating to continue oxygen. R5's medical record lacked a current oxygen order to include a description of the oxygen service, diagnostic indication, frequency, duration, route, and type of inhalation apparatus. In addition, the diagnostic indication on the original order did not match the indication licensee was listing on the MAR. On August 30, 2023, at 7:20 a.m., the surveyor observed oxygen concentrator in R5's bedroom next to bed. Concentrator was set to deliver one liter of oxygen when turned on and tubing attached to nasal cannula was attached to concentrator and looped through bed rail. R5 stated the unlicensed personnel (ULP) assist R5 to put oxygen tubing on and turn on concentrator at bedtime. In the morning, R5 removes the tubing, loops it through the bed rail, and shuts off the concentrator herself. On August 31, 2023, at 2:14 p.m., clinical nurse supervisor (CNS)-A, stated ULPs assist with turning on the oxygen at night, R5's daughter	01970		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01970	Continued From page 25 changes the tubing and nasal cannula, R5 removes the oxygen and shuts off the concentrator. The licensee's Content of Medication Prescriptions and Treatment or Therapy Orders policy dated January 13, 2023, indicated an order for a treatment or therapy must contain the name of the resident, a description of the treatment therapy to be provided, the frequency, other information needed to administer the treatment or therapy, and any parameter or instructions to modify the therapy if applicable. In addition, the policy indicated the RN will assure the prescriber renews a medication prescription or treatment or therapy order at least every 12 months. To keep orders up to date, the RN will provide the resident/ resident's representative a list of current orders to take to any appointments with the physician or prescriber. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20559	A. BUILDING: _____ B. WING _____	08/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COUNTRY VILLA	520 1ST STREET NE SARTELL, MN 56377

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 26 services were provided according to acceptable health care and medical, or nursing standards for one of four residents (R2) utilizing a consumer portable bed rail was installed per manufacturer guidelines. 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: On August 30, 2023, at 10:30 a.m., R2 stated she used the device on the right upper side of the bed "all the time, to get up." R2 stated her family had purchased the adjustable bed frame, but she never used the remote to move the head of the bed up or down, always leaving it "flat." R2 stated she wouldn't be able to get up or into bed independently without the device and stated, "It's a life saver." The surveyor observed the handle-type device had a large rectangular shaped metal-framed base that was tucked under the mattress on the adjustable bed frame, but could not see how the device was attached. The device was secure and did not move when pulled. On August 30, 2023, at 11:07 a.m., the surveyor and registered nurse (RN)-E entered R2's apartment with permission, and observed under the mattress where the device was placed. The device was attached to the adjustable bed frame on the left side of the bed frame with a long nylon strap.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20559	A. BUILDING: _____ B. WING _____	08/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COUNTRY VILLA	520 1ST STREET NE SARTELL, MN 56377

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 27 R2's diagnoses included essential hypertension (high blood pressure), diplopia (double vision), intervertebral disc degeneration, weakness, insomnia, tremor, and urinary incontinence. R2's Service Plan Agreement dated effective April 28, 2023, indicated R2 received services including assistance with laundry, housekeeping, blood sugar monitoring, insulin administration, and safety checks. R2's Master Assessment dated June 13, 2023, identified as the 90-day / annual assessment, indicated R2 utilized a manual wheelchair, and a 4 wheeled walker, was independent with ambulation, transfers, and getting in and out of bed, and required fall risk safety checks. The assessment section titled Functional Capabilities, number 5 noted the supporting resources for resident to get in and out of bed, and contained an option for a bed cane or bed rails, was marked as N/A (non applicable). R2's Vulnerability Assessment/Abuse Prevention Plan dated June 13, 2023, noted, "A. Side rail / bed positioning device assessment is in place," "B. Side rail / bed positioning agreement is in place," and "C. Staff to report concerns with side rails / bed positioning device to nurse promptly." The plan also included the resident would experience improved ability with bed mobility and positioning, remain free from injury, and the side rails / positioning device would remain in proper working order. R2's Bed Rail / Positioning Device Assessment dated June 13, 2023, noted the use of an upper assist bar/grab bar was under consideration, and indicated R2 was able to make wishes known,	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02310	Continued From page 28 was alert and oriented to person and place, had intermittent confusion, and impaired vision. The assessment also noted R2 was ambulatory, expressed a desire to have a device in place while in bed for safety/comfort, was visually challenged, continent of bladder, and sometimes incontinent of bowel. Also noted, the device assisted R2 in turning side-to-side, assisted in pulling from lying to sitting position, and assisted in supporting self and safe entry into bed and out of bed, moving up and down in bed, improving / maintaining comfortable body positioning, and providing a sense of security. The assessment noted it did not limit the resident's freedom of movement, sensory stimulation, obstruct the resident's view, or limit the access to their person or environment. Also noted, the device was not considered a restraint, and was recommended. Measurements for zone 1 within the rail were 3.75 inches, zone 2 under the rail, between the supports, or next to a single rail support 3.75 inches, zone 3 between the rail and mattress 1.0 inch, and zone 4 under the rail, at the end of the rail zero inches. The assessment noted R2 was assessed for the use of a mobility bar due to positioning assistance, and the mobility bar was recommended for assistance with positioning, was not a restraint, and the risks, benefits, and alternatives were discussed with the resident/resident representative, and they wished to proceed with the installation. It also noted the mobility bar was installed per manufacturer's guidance. The Stander Bed Handle instructions, dated August 10, 2021, noted the product must be installed on the bed frame, and to never use the product without a bed frame. Further, the instructions included "Do not use on adjustable beds unless otherwise specified in ASSEMBLY	02310		

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	20559	A. BUILDING: _____ B. WING _____	08/31/2023

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02310	Continued From page 29 INSTRUCTIONS." The ASSEMBLY INSTRUCTIONS included the specifications, which indicated under compatibility, "Not intended for use on adjustable beds." In addition, under ADDITIONAL WARNINGS, the instructions noted this product is not intended to be used by individuals who have paralysis, symptoms of dementia, sleeping disorders, incontinence, pain, uncontrolled body movement, or are unable to get out of bed and walk safely without assistance, confusion, restlessness, terminal restlessness, or are under the influence of medications, drugs, or any substance that could impair their balance or judgement, or any other unforeseeable reasons that could affect the users physical and mental ability to safely use the product. On August 30, 2023, at 12:28 p.m., clinical nurse supervisor (CNS)-A stated devices are installed to beds when the resident or family request, or when they receive a doctor's order to do so. CNS-A stated they utilized two devices that the licensee determined "fit the guidelines," specifically referring to the Food and Drug Administration (FDA) guidelines, and stated the resident purchased the device themselves. CNS-A stated the nurses complete an assessment and make sure the device is appropriate, discuss risk and benefits of the device with the resident and family, and have them sign that this has been discussed. CNS-A stated if a device is placed by the resident or family that doesn't meet the guidelines, the device is removed. CNS-A stated she was aware that R2 had an adjustable bed frame and that the manufacturer's guidelines indicated the device was not intended for use with an adjustable bed frame; however, stated, "It doesn't say 'never use,' it just says 'not intended." CNS-A stated R2 and her family were aware of this and still chose	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02310	Continued From page 30 to use the device, although stated this was not documented anywhere. CNS-A stated she had signed up for the CPSC (United States Consumer Product Safety Commission) emails and would be alerted if the device was recalled, and looked at the website often. R2's record lacked evidence the licensee had installed the consumer portable bed rail according to manufacturer's guidelines, offered alternatives, discussed, and offered interventions to mitigate safety risks, and ensured the portable bed rail was installed and secured per manufacturer's guidelines. The licensee's Assessing the Safety of Side Rails policy, dated January 13, 2023, indicated upon admission and ongoing the RN would assess the safety of side rails, and would educate the resident, the resident's representative and/or family members about the risks related to side rails, and if the resident's side rail did not appear to meet FDA standards, the RN would recommend to the resident, the resident's representative, and the resident's involved family members, that the side rail be removed and would recommend alternative options to reduce the risk of a fall out of bed. The RN would document these conversations and recommendations. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs), indicated when a portable bed rail was not installed per manufacturer guidelines, "The licensee should offer alternatives, discuss and offer interventions to mitigate safety risks, and ensure the portable bed rail is installed and secured per manufacturer's guidelines."	02310		

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02310	Continued From page 31 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

DEPARTMENT OF HEALTH

Type: Full
Date: *08/28/23*
Time: 12:05:39
Report: 1037231219

Food and Beverage Establishment Inspection Report

Location:
The Country Villa
520 1st Street Ne
Sartell, MN56377
Benton County, 05

Establishment Info:
ID #: 0038725
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3202538450
ID #:

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

The following orders were issued during this inspection.

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

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

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

RAW SHELLED EGGS WERE STORED ABOVE READY TO EAT FOOD AND BEVERAGES IN THE ACTIVITIES UPRIGHT COOLER IN THE APARTMENTS KITCHEN. STORE ALL RAW FOODS BELOW READY TO EAT FOODS.

Comply By: 08/28/23

3-600 Food Identity

3-603.11A ***** Priority 2 *****

MN Rule 4626.0442A Inform consumers of the increased risk of consuming raw, undercooked or unprocessed animal foods or shellfish by way of a disclosure and reminder.

PROVIDE A CONSUMER ADVISORY ON THE DRAKE'S MENU WITH ASTERISKS ON THE ITEMS THAT CAN BE ORDERED UNDERCOOKED, SUCH AS EGGS AND HAMBURGERS. FACT SHEET ATTACHED WITH REPORT.

Comply By: 09/28/23

4-300 Equipment Numbers and Capacities

4-302.13B ***** Priority 2 *****

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

PROVIDE AN IRREVERSIBLE REGISTERING TEMPERATURE MEASURING DEVICE TO MEASURE THE UTENSIL LEVEL IN THE HOT WATER DISHWASHER.

Comply By: 09/11/23

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

3-302.12

MN Rule 4626.0240 Properly label all working containers holding food or food ingredients that are removed from orginal packages with the common name of the food. Label the food in English and any other languages used by employees who handle food.

THE BULK FLOUR AND SUGAR CONTAINERS WERE NOT LABELED IN THE DRAKE'S KITCHEN. LABEL THE CONTAINERS WITH THE COMMON NAME OF THE FOOD.

Comply By: 09/04/23

5-200A Plumbing: approved materials/design

5-201.11B

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

THE HOT WATER FAUCET HANDLE WAS BROKEN OFF THE HAND SINK NEAR THE ENTRANCE TO THE DRAKE'S KITCHEN AT THE TIME OF INSPECTION. REPAIR THE FAUCET HANDLE.

Comply By: 09/04/23

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200 at Degrees Fahrenheit
Location: SANITIZER BUCKET - VILLA KITCHEN
Violation Issued: No

Hot Water: = at 162 Degrees Fahrenheit
Location: DISHWASHER - VILLA KITCHEN
Violation Issued: No

Hot Water: = at 169 Degrees Fahrenheit
Location: DISHWASHER - APARTMENTS KITCHEN (AFTER BOOSTER HEATER TURNED ON)
Violation Issued: No

Acid: = 700 at Degrees Fahrenheit
Location: SANITIZER BUCKET - APARTMETNS KITCHEN
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Hot Holding
Temperature: 182 Degrees Fahrenheit - Location: POTATO SOUP - VILLA KITCHEN
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 37 Degrees Fahrenheit - Location: POTATO SALAD - VILLA KITCHEN
Violation Issued: No

Process/Item: Milk Carton Server
Temperature: 40 Degrees Fahrenheit - Location: MILK CARTON - APARTMENTS KITCHEN
Violation Issued: No

Type: Full
Date: *08/28/23*
Time: 12:05:39
Report: 1037231219
The Country Villa

Food and Beverage Establishment Inspection Report

Process/Item: Hot Holding
Temperature: 142 Degrees Fahrenheit - Location: BAKED POTATO - APARTMENTS KITCHEN
Violation Issued: No

Process/Item: Cold Holding
Temperature: 37 Degrees Fahrenheit - Location: CRAB PASTA SALAD - APARTMENTS KITCHEN
Violation Issued: No

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

Process/Item: Prep Cooler
Temperature: 40 Degrees Fahrenheit - Location: CHICKEN SALAD - DRAKES
Violation Issued: No

Process/Item: Prep Cooler
Temperature: 41 Degrees Fahrenheit - Location: RICE PILAF - DRAKES
Violation Issued: No

Process/Item: Prep Cooler - DRAWER
Temperature: 41 Degrees Fahrenheit - Location: PRECOOKED DICED CHICKEN - DRAKES
Violation Issued: No

Process/Item: Prep Cooler
Temperature: 38 Degrees Fahrenheit - Location: SLICED TOMATO - DRAKES
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 38 Degrees Fahrenheit - Location: PICO - DRAKES
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 41 Degrees Fahrenheit - Location: SLICED TURKEY - DRAKES
Violation Issued: No

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

Type: Full
Date: *08/28/23*
Time: 12:05:39
Report: 1037231219
The Country Villa

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 inspection report number 1037231219 of 08/28/23.

Certified Food Protection Manager: KASEY B. DAVIS

Certification Number: 81064 Expires: 11/03/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: Michelle L Hovanes

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

Report #: 1037231219

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

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

Date 08/28/23
Time In 12:05:39
Time Out

The Country Villa	Address: 520 1st Street Ne	City/State: Sartell, MN	Zip Code: 56377	Telephone: 3202538450
License/Permit #: 0038725	Permit Holder	Purpose of Inspection: Full	Est Type	Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

			COS	R
Safe Food and Water				
30	(IN) OUT N/A	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT (N/A)	Variance obtained for specialized processing methods		
Food Temperature Control				
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A (N/O)	Plant food properly cooked for hot holding		
35	IN OUT N/A (N/O)	Approved thawing methods used		
36		Thermometers provided & accurate		
Food Identification				
37	X	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		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	X	Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 08/28/23

Inspector (Signature) Michelle L Hoversos