Electronically Delivered

August 22, 2025

Licensee
Shiloh Assisted Living
5384 Country Care Lane
Pequot Lakes, MN 56472

RE: Project Number(s) SL34980016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 2, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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. 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;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in

§ 144G.20;
Level 5: a fine of $5,000 per violation, in addtion to any enforcement mechanism authorized in § 144G.20.

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

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

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

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

The correction order documentation should include the following:

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

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

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

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34980	A. BUILDING: _____ B. WING _____	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHILOH ASSISTED LIVING	5384 COUNTRY CARE LANE PEQUOT LAKES, MN 56472

(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: SL34980016 On June 30, 2025, through July 2, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 50 residents; 50 receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the clinical nurse supervisor (CNS) developed and implemented a staffing plan to determine staffing levels to meet the needs of all residents, which included reviewing the staffing plan at least twice per year and failed to post an accurate daily work schedule at the beginning of each work shift. This had the potential to affect all residents, staff, and visitors.	0 470		

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0 470	Continued From page 2 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: The licensee held an assisted living with dementia care license and was licensed for a capacity of 70 residents, with a current census of 50 residents. During the entrance conference on June 30, 2025, at 10:45 a.m., executive director (ED)-C, CNS-A, and licensed assisted living director (LALD)-B stated the licensee was familiar with the current minimum living requirements. In addition, they stated they had three shifts as follows: - morning shift (7:00 a.m. to 3:00 p.m.) two unlicensed personnel (ULP) in Shiloh 1 building, one ULP in Shiloh 2 building, and two ULP in Upper Dakota building; - evening shift (3:00 p.m. to 11:00 p.m.) two ULP in Shiloh 1 building, one ULP in Shiloh 2 building, and two ULP in Upper Dakota building; and - night shift (11:00 p.m. to 7:00 a.m.) one ULP in Shiloh 1 building, one ULP in Shiloh 2 building, and 1 ULP in Upper Dakota building. The licensee's Staffing Plan policy reviewed February 12, 2025, and May 16, 2025, noted the following: - morning shift with two ULP in Shiloh 1, two ULP in Shiloh 2, and two ULP in Upper Dakota;	0 470		

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0 470	Continued From page 3 - afternoon shift with two ULP in Shiloh 1, two ULP in Shiloh 2, and two ULP in Upper Dakota; and - night shift with one ULP in Shiloh 1, one ULP in Shiloh 2, and one ULP in Upper Dakota. The licensee's daily posting in the Shiloh and Upper Dakota buildings noted: - morning shift with two ULP in the Shiloh building and two ULP in the Upper Dakota building; - afternoon shift with two ULP in the Shiloh building and two ULP in the Upper Dakota building; and - night shift with one ULP in the Shiloh building and one ULP in the Upper Dakota building and one float ULP. The daily posting lacked the work schedules for each direct-care staff member including the days and hours worked. On July 1, 2025, at 2:35 p.m., ED-C stated they were down to one ULP in Shiloh 2 now with the decreased census, but had not redone the staffing plan. ED-C stated this happened shortly after the last review of the staffing plan on May 16, 2025. No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days 7	0 470		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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

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0 480	Continued From page 5 existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated June 30, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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0 480	Continued From page 6 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 500 SS=F	144G.41 Subd. 2 Policies and procedures Each assisted living facility must have policies and procedures in place to address the following and keep them current: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (2) conducting and handling background studies on employees; (3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (4) handling complaints regarding staff or services provided by staff; (5) conducting initial evaluations of residents' needs and the providers' ability to provide those services; (6) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (7) orientation to and implementation of the assisted living bill of rights; (8) infection control practices; (9) reminders for medications, treatments, or exercises, if provided; (10) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; (11) ensuring that nurses and licensed health	0 500		

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0 500	Continued From page 7 professionals have current and valid licenses to practice; (12) medication and treatment management; (13) delegation of tasks by registered nurses or licensed health professionals; (14) supervision of registered nurses and licensed health professionals; and (15) supervision of unlicensed personnel performing delegated tasks. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they had met the requirements of licensure, by attesting the managerial officials who were in charge of the day-to-day operations, had developed and implemented current policies and procedures, as required. 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: During the entrance conference on June 30, 2025, at 10:45 a.m., the licensee's policies and procedures were requested. The provided policies lacked development of: - supervision of registered nurses and licensed health professionals. The licensee's Application for Assisted Living	0 500		

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0 500	Continued From page 8 License signed by authorized agent (AA)-H on October 31, 2024, included a check mark indicating AA-H attested to having all the required policies and procedures. On July 2, 2025, at 11:05 a.m., executive director (ED)-C stated she was unable to locate the above required policy. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 500		
0 650 SS=E	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as	0 650		

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0 650	Continued From page 9 required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the employee record contained the required content for two of three employees (clinical nurse supervisor/CNS-A, unlicensed personnel/ULP-F). 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: CNS-A CNS-A was hired on February 27, 2023, to provide direct care services to residents of the facility. CNS-A's employee record lacked documented evidence of the following required annual training: - reporting maltreatment of vulnerable adults or minors; and - review of the provider's policies and procedures. ULP-F ULP-F was hired on October 4, 2018, to provide direct care services to residents of the facility. On July 1, 2025, at 8:11 a.m., the surveyor observed ULP-F assist R3 with personal cares.	0 650		

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0 650	Continued From page 10 ULP-F's employee record lacked documented evidence of the following required annual training: - reporting maltreatment of vulnerable adults or minors; and - principles of person-centered planning/service delivery. On July 2, 2025, at 11:40 a.m., executive director (ED)-C and CNS-A stated the required training had been provided but not documented in the employee records. The licensee's Personnel Files Employee Records policy dated August 1, 2021, noted the employee records would include a record of annual training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
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	0 680		

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0 680	Continued From page 11 (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the required content defined in Appendix Z. This had the potential to affect residents receiving services under the assisted living license, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the facility tour on June 30, 2025, at 11:20 a.m., with clinical nurse supervisor (CNS)-A, the surveyor observed two attached buildings (Shiloh 1 and Shiloh 2) to have resident rooms, a dining room, common lounge area, and outdoor seating	0 680		

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	34980	A. BUILDING: _____ B. WING _____	07/02/2025

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0 680	Continued From page 12 areas. The campus also included another building (Upper Dakota) with resident rooms, a dining room, and common sitting areas. This building also included a gated outside area for residents. The licensee's white Emergency Preparedness binder, dated reviewed May 5, 2025, lacked the following required content: - hazard vulnerability assessment (HVA) to include community-based risks; - policy and procedure to address the use of volunteers, including the process for integration; - current list of the names and contact information of staff; - means, in event of evacuation, to release resident information as permitted under 45 CFR 164.510(b)(1)(ii); and - means of providing information about general condition/location of residents under the facility's care as permitted under 45 CFR 164.510(b)(4). On July 2, 2025, at 12:00 p.m., executive director (ED)-C stated the HVA did not include community-based risks, and the plan lacked the above required content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced	0 775		

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0 775	Continued From page 13 by: Based on observation and interview, the licensee failed to comply with the requirements of the Minnesota State Fire Code. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 a facility tour on July 1, 2025, from 10:30 a.m. to 12:30 p.m., with operations supervisor (OS)-D and maintenance (M)-E, the following observations were made of non-compliance with the requirements of the Minnesota State Fire Code (MSFC) in Minnesota Rules Chapter 7511: There were delayed egress locking systems with special locking arrangements and controlling egress at all marked exit doors leading to the exterior exit path in Shiloh one building and Upper Dakota building. There was not an emergency release switch in the nurse station or other approved location to release all delayed egress doors to the open position in order for occupants to exit in the event of an emergency in the Upper Dakota building. It was explained to OS-D, and M-E, that an emergency release switch to release to open all delayed egress doors is required to be installed at the nurse station or other approved location.	0 775		

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0 775	Continued From page 14 During record review and interview on July 1, 2025, at 10:20 a.m., OS-D, and M-E, stated procedures of operation of the delayed egress locking systems were not included in the facility Fire Safety and Evacuation Plan (FSEP). It was explained to OS-D, and M-E, that procedures for operation of the delayed egress locking system are required to be included in writing in the FSEP in accordance with MSFC in Minnesota Rules Chapter 7511. The combination lighted exit sign/emergency light fixture was removed from the mount with wires exposed inside the I pod in the Upper Dakota building. Several combination lighted exit signs/emergency lights did not operate to test emergency back up power supply when the test button was activated in the Upper Dakota building. During the facility tour OS-D, and M-E, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and	0 800		

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0 800	Continued From page 15 repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: On a facility tour on July 1, 2025, from 10:30 a.m. to 12:30 p.m., with operations supervisor (OS)-D and maintenance (M)-E, the surveyor made the following observations of facility disrepair: During the tour recent documentation was requested indicating the private sewer system was inspected and compliant with applicable regulations. During the tour OS-D, stated they would send the recent requested documentation by end of workday Wednesday July 2, 2025. No further information was provided. The wall behind the chairs was damaged with	0 800		

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0 800	Continued From page 16 holes through the drywall wall membrane in the F pod of the upper Dakota building living room area. During the tour M-E, stated the holes are caused by the chairs being reclined and contacting the wall and they plan to install a compliant wood wainscot to protect the drywall surface. During the facility tour OS-D, and M-E, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the	0 810		

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0 810	Continued From page 17 proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content, provide required drills in sequence. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: On July 1, 2025, at 9:45 a.m., executive director (ED)-C, and operations supervisor (OS)-D, provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility.	0 810		

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0 810	Continued From page 18 FIRE SAFETY AND EVACUATION PLAN The licensee provided FSEP undated, failed to include the following: The location and number of resident sleeping rooms were not accurately identified on the posted FSEP evacuation floor plan and on the doors of the resident rooms in the Upper Dakota building. The resident room numbers on the posted evacuation floor plans were number one through ten and the numbers on the resident room doors were in the 600's. It was explained the resident room numbers are required to be included on the evacuation floor plan and coincide with the numbers on the doors in order to lead building occupants to the exits in the event of a fire or similar emergency. The available FSEP did not identify specific fire protection actions for residents as evident by not providing procedures for residents to take in this specific facility in the event of a fire or similar emergency in writing in the FSEP. During an interview on July 1, 2025, at 10:10 a.m., OS-D, and ED-C, stated documentation for resident procedures during a fire or similar emergency were not available in the FSEP and the evacuation floor plan and resident room numbering was not accurate in the Upper Dakota building. DRILLS Record review of the available documentation indicated the licensee failed to conduct evacuation drills for employees twice per year,	0 810		

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0 810	Continued From page 19 per shift with at least one evacuation drill every other month as evident by providing documentation evacuation drills were completed in January and April 2025 only. During an interview on July 1, 2025, at 10:10 a.m., OS-D, and ED-C, stated documentation was not available indicating evacuation drills were completed every other month throughout 2025. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan.	01640		

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01640	Continued From page 20 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included a signature or other authentication by the facility to document agreement on the services to be provided for one of three residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included generalized anxiety disorder, hypertension, and diabetes mellitus type II. R1's Service Plan dated July 2, 2025, (printed and signed during the course of the survey) indicated R1 received services including assistance with bathing, grooming, and medication administration. On July 1, 2025, at 2:15 p.m., clinical nurse supervisor (CNS)-A stated the service plan had been completed along with the assessment on June 23, 2025. However, she was unable to print this out or get it signed at that time. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		

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01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any	01730		

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01730	Continued From page 22 changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to complete a medication reconciliation for one of three residents (R6). 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: R6's diagnoses included anxiety disorder and pain. R6's Service Plan dated June 3, 2025, indicated R6 received services including assistance with activities, bed mobility, and medication administration. On June 30, 2025, at 11:20 a.m., during the facility tour with clinical nurse supervisor (CNS)-A, the surveyor observed the medication cart in the Shiloh 1 building. The cart contained R6's diazepam (anti-anxiety medication) with the label for 5 milligrams (mg) two times daily and as needed.	01730		

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01730	Continued From page 23 R6's prescriber orders dated March 5, 2025, included: - "Diazepam 5 mg Tab [Tablet] administer 1 tablet by mouth daily during the night as needed and one time during the day". R6's Med (Medication) Sheets for July 2025, included: - "Diazepam 5 mg Tab Take 1 tablet by mouth once at bedtime by mouth 1 x a day"; and - "Diazepam 5 mg Tab administer 1 tablet by mouth daily during the night as needed and one time during the day takes all meds [medications] with pudding and orange juice (prefers chocolate pudding) - Up To 2 times per day". On July 1, 2025, at 11:00 a.m., CNS-A stated a medication reconciliation had not been completed to ensure the prescriber order for diazepam matched the medication administration record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01750 SS=E	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions	01750		

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01750	Continued From page 24 in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure as needed (PRN) medications included parameters for administration for two of three residents (R3, R6). 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: R3 R3's diagnoses included major depressive disorder, chronic obstructive pulmonary disorder, and hypertension. R3's Service Plan dated June 7, 2023, indicated R3 received services including assistance with activities, bathing, oxygen management, and medication administration. R3's Standing Orders dated June 25, 2025, included: - Benadryl 25 milligrams (mg) 1-2 tablets up to three times daily by mouth as needed. R6	01750		

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01750	Continued From page 25 R6's diagnoses included anxiety disorder and pain. R6's Service Plan dated June 3, 2025, indicated R6 received services including assistance with activities, bathing, bed mobility, and medication administration. R6's prescriber orders dated March 5, 2025, included: - Albuterol HFA 90 micrograms (mcg) inhale 1-2 puffs every four hours as needed for wheezing and shortness of breath. On July 1, 2025, at 3:45 p.m., clinical nurse supervisor (CNS)-A stated all residents had the same standing orders signed, and stated there should be specific parameters for administration of all orders. The licensee's Medication & Treatment Orders - Receiving policy dated August 1, 2021, noted the content of medication orders must include the name, dosage, frequency, route, indication, and directions for use. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01780 SS=F	144G.71 Subd. 10 Medication management for residents who will (a) An assisted living facility that is providing medication management services to the resident must develop and implement policies and procedures for giving accurate and current medications to residents for planned or	01780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34980	A. BUILDING: _____ B. WING _____	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHILOH ASSISTED LIVING	5384 COUNTRY CARE LANE PEQUOT LAKES, MN 56472

(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
01780	Continued From page 26 unplanned times away from home according to the resident's individualized medication management plan. The policies and procedures must state that: (1) for planned time away, the medications must be obtained from the pharmacy or set up by the licensed nurse according to appropriate state and federal laws and nursing standards of practice; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement policies and procedures for giving accurate and current medications for those residents who received medication management services having planned and unplanned times away from home. 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: During the entrance conference on June 30, 2025, at 10:45 a.m., executive director (ED)-C and clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to the licensee's residents. The licensee's Medication Administration - Outings and Unplanned Time Away policy dated August 1, 2021, lacked the following required content:	01780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34980	A. BUILDING: _____ B. WING _____	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHILOH ASSISTED LIVING	5384 COUNTRY CARE LANE PEQUOT LAKES, MN 56472

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01780	Continued From page 27 - for planned time away, the medications must be obtained from the pharmacy or set up by the registered nurse (RN). On July 2, 2025, at 11:10 a.m., ED-C stated the above policy lacked the required verbiage. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01780		
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,	01790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34980	A. BUILDING: _____ B. WING _____	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHILOH ASSISTED LIVING	5384 COUNTRY CARE LANE PEQUOT LAKES, MN 56472

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01790	Continued From page 28 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; (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 interview and record review, the licensee failed to ensure the registered nurse (RN) developed comprehensive written procedures for the unlicensed personnel (ULP)	01790		

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	34980	A. BUILDING: _____ B. WING _____	07/02/2025

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SHILOH ASSISTED LIVING	5384 COUNTRY CARE LANE PEQUOT LAKES, MN 56472

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01790	Continued From page 29 providing medications for residents having unplanned time away when the licensed nurse was not available. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on June 30, 2025, at 10:45 a.m., executive director (ED)-C and clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to residents at the facility. The licensee lacked written procedures to include: - a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel. On July 2, 2025, at 9:50 a.m., ED-C stated the licensee's Medication Administration - Outings and Unplanned Time Away policy dated August 1, 2021, lacked the above required content. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34980	A. BUILDING: _____ B. WING _____	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHILOH ASSISTED LIVING	5384 COUNTRY CARE LANE PEQUOT LAKES, MN 56472

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01820	Continued From page 30	01820		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure complete written or electronically recorded prescriptions were obtained for one of three residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on June 30, 2025, at 10:45 a.m., clinical nurse supervisor (CNS)-A and executive director (ED)-C stated the licensee provided medication management services to residents at the facility. R1's diagnoses included generalized anxiety disorder, hypertension, and diabetes mellitus type II. R1's Service Plan effective June 23, 2025, indicated R1 received services including assistance with bathing, dressing, and medication	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34980	A. BUILDING: _____ B. WING _____	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHILOH ASSISTED LIVING	5384 COUNTRY CARE LANE PEQUOT LAKES, MN 56472

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01820	Continued From page 31 administration. R1's prescriber orders dated December 11, 2024, included: - cyclobenzaprine 10 milligrams (mg) three times daily as needed. R1's prescriber orders dated May 18, 2025, included: - cyclobenzaprine 0 mg once daily as needed. R1's June 2025, Med (Medication) Admin (Administration) Summary included: - cyclobenzaprine 10 mg by mouth three times daily as needed. On July 1, 2025, at 2:15 p.m., CNS-A stated the current signed order had a typo error as zero milligrams, and said both orders were signed by the same provider. The licensee's Medication & Treatment Orders - Receiving policy dated August 1, 2021, noted all orders must contain the name of the drug, dosage, frequency, route, indication, and directions for use. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34980	A. BUILDING: _____ B. WING _____	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01960	Continued From page 32 administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure treatment or therapies were administered as ordered, or to document the reason they were not administered as ordered, for one of one resident (R3) receiving oxygen management. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on June 30, 2025, at 10:45 a.m., clinical nurse supervisor (CNS)-A stated the licensee provided treatment and therapy management services to the licensee's residents including oxygen management. R3's diagnoses included major depressive disorder, chronic obstructive pulmonary disorder, and hypertension.	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34980	A. BUILDING: _____ B. WING _____	07/02/2025

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SHILOH ASSISTED LIVING	5384 COUNTRY CARE LANE PEQUOT LAKES, MN 56472

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01960	Continued From page 33 R3's Service Plan dated June 7, 2023, indicated R3 received services including assistance with activities, bathing, oxygen management, and medication administration. On July 1, 2025, at 7:45 a.m., with permission from R3, the surveyor observed while unlicensed personnel (ULP)-F provided medications to R3 in his room. At this time, ULP-F stated the oxygen was set to 5 liters per minute (LPM). On July 1, 2025, at 8:11 a.m., with permission from R3, they surveyor observed while ULP-F assisted R3 with morning cares in the bathroom. At this time, R3 had a portable oxygen tank on his wheeled walker. After morning cares were completed, ULP-F placed the oxygen tubing in R3's nose and set it to 4 LPM. At this time, ULP-F stated she believed R3's oxygen order was between 4-5 LPM at all times. After completion of cares, ULP-F walked R3 to the dining room with his walker and assisted him to sit at the table for breakfast. R3's prescriber orders dated June 24, 2025, noted oxygen delivery as ordered via nasal cannula: - at rest: no oxygen; - with exertion: 2 LPM; and - night (sleep) 4 LPM. On July 1, 2025, at 3:45 p.m., CNS-A stated this was not a clear order, and stated the oxygen should have been set to 2 LPM when up and 4 LPM when in bed. Executive director (ED)-C stated sometimes R3 adjusts the oxygen amount himself. No further information was provided.	01960		

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	34980	A. BUILDING: _____ B. WING _____	07/02/2025

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SHILOH ASSISTED LIVING	5384 COUNTRY CARE LANE PEQUOT LAKES, MN 56472

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01960	Continued From page 34 TIME PERIOD FOR CORRECTION: Seven (7) days	01960		

St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Shiloh Assisted Living
5384 Country Care Lane
Pequot Lakes, MN 56472
Crow Wing County
Parcel:

Phone:

License Info

License: HFID 34980

Risk:
License:
Expires on:
CFPM: Michaele Nelson
CFPM #: ; Exp: 1/21/2028

Inspection Info

Report Number: F6808251020
Inspection Type: Full - Single
Date: 6/30/2025 Time: 11:15 AM
Duration: minutes
Announced Inspection: Yes
Total Priority 1 Orders: 0
Total Priority 2 Orders: 2
Total Priority 3 Orders: 0
Delivery:

New Order: 3-500C Microbial Control: date marking
3-501.17B *Priority Level: Priority 2 CFP#: 23*
MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.
COMMENT: DATE MARK FROZEN FOODS THAT ARE GOING TO BE THAWED TO NOT EXCEED THE 7 DAY DISCARD TIME PERIOD. ROAST BEEF, DATED 6/4, WAS NOT MARKED WITH A THAW DATE.
Comply By: 6/30/2025 Originally Issued On: 6/30/2025

New Order: 5-100 Water
5-103.11 *Priority Level: Priority 2 CFP#: 50*
MN Rule 4626.1015 The water source and system must be of sufficient capacity to meet the peak water demands of the food establishment. Hot water generation and distribution systems must also be sufficient to meet the peak hot water demands throughout the food establishment.
COMMENT: REPAIR/REPLACE THE WATER HEATER THAT SUPPLIES THE 3-COMP. SINK IN SHILOH 2 KITCHEN.
Comply By: 7/14/2025 Originally Issued On: 6/30/2025

Food & Beverage General Comment

INSPECTED ALL THREE KITCHENS.

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the St Cloud District Office inspection report number F6808251020 from 6/30/2025

Lee Ann Austin

Establishment Representative

Lee Ann Austin,
Public Health Sanitarian 3
320-223-7341
lee.ann.austin@state.mn.us

St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301

Temperature Observations/Recordings

Establishment Info

Shiloh Assisted Living
Pequot Lakes
County/Group: Crow Wing County

Inspection Info

Report Number: F6808251020
Inspection Type: Full
Date: 6/30/2025
Time: 11:15 AM

Food Temperature: Product/Item/Unit: roast beef**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 39 Degrees F.
Comment: SHILOH 2 KITCHEN
Violation Issued?: No

Food Temperature: Product/Item/Unit: PASTA SALAD**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 40 Degrees F.
Comment: SHILOH 1 KITCHEN
Violation Issued?: No

Food Temperature: Product/Item/Unit: PASTA SALAD**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 40 Degrees F.
Comment: DAKOTA KITCHEN
Violation Issued?: No

New Record: Product/Item/Unit: ; Temperature Process:
Location: at Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: CASSEROLE**; Temperature Process:** Hot-Holding
Location: Oven at 210 Degrees F.
Comment: DAKOTA KITCHEN
Violation Issued?: No

St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301

Sanitizer Observations/Recordings

Establishment Info

Shiloh Assisted Living
Pequot Lakes
County/Group: Crow Wing County

Inspection Info

Report Number: F6808251020
Inspection Type: Full
Date: 6/30/2025
Time: 11:15 AM

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** Dish Machine
Location: Kitchen **Equal To** 200 PPM
Comment: SHILOH 2 KITCHEN
Violation Issued?: No

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** Spray Bottle
Location: Kitchen **Equal To** 200 PPM
Comment: SHILOH 2 KITCHEN
Violation Issued?: No

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Kitchen **Equal To** 163 Degrees F.
Comment: SHILOH 1 KITCHEN
Violation Issued?: No

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Kitchen **Equal To** 162 Degrees F.
Comment: DAKOTA KITCHEN
Violation Issued?: No