Electronically Delivered

March 7, 2025

Licensee
SACRED HEART ASSISTED LVG APTS
1202 12th Street Southwest
Austin, MN 55912

RE: Project Number(s) SL20386016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 5, 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 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.

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

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. 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

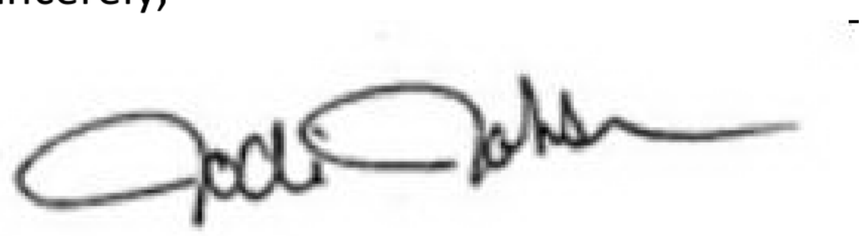
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms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



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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20386	A. BUILDING: _____ B. WING _____	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SACRED HEART ASSISTED LVG APTS	1202 12TH ST SW AUSTIN, MN 55912

(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 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: SL20386016-0 On February 3, 2025, through February 5, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 25 residents; 22 receiving services under the Assisted Living Facility 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.	
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and	0 510		

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0 510	Continued From page 1 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 infection control program that complies with accepted health care, medical and nursing standards for infection control. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 February 3, 2025, at 11:07 a.m. during the entrance conference, licensed assisted living director (LALD)-A stated the licensee currently had one resident (R7) who had tested positive for influenza. LALD-A further stated they had placed	0 510		

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0 510	Continued From page 2 three other residents (R6, R8, R5) in isolation for exhibiting symptoms. On February 3, 2025, at 12:35 p.m., the surveyor observed a yellow plastic three-drawer cart outside of R5's room that had hand sanitizer and face shields on top. The cart contained disposable gowns, gloves, and surgical masks. There was no signage on the door to indicated precautions should be taken or that the resident was in isolation. Unlicensed personnel (ULP)-C stated R5 was on isolation precautions for influenza due to symptoms R5 had been exhibiting. ULP-C stated gloves, gown, eye protection, and surgical mask were required to enter the room. The surveyor observed ULP-C don PPE, administer an eye drop to R5, and after leaving R5's room, PPE was removed in the hallway and disposed into the garbage container outside of R5's room. On February 3, 2025, at 2:07 p.m., the surveyor observed a yellow plastic three-drawer cart outside of R7's room and a blue plastic three-drawer cart outside of R8's room that had hand sanitizer and face shields on top. The carts contained disposable gowns, gloves, and surgical masks. There was no signage on R7 or R8's door to indicate precautions should be taken or that the resident was in isolation. In addition, a garbage can was in the hallway next to R7's cart with used personal protective equipment (PPE). On February 3, 2025, at 2:27 p.m., the surveyor observed a blue plastic three-drawer cart outside of R6's room that had hand sanitizer and face shields on top. The cart contained disposable gowns, gloves, and surgical masks. There was no signage on the door to indicated precautions should be taken or that the resident was in	0 510		

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0 510	Continued From page 3 isolation. In addition, a garbage can was in the hallway next to R6's room. On February 4, 2025, at 1:13 p.m. licensed practical nurse/licensed assisted living director (LPN/LALD)-A stated R7, R6, R8, and R5 were on droplet precautions and staff were to don gloves, mask, and eye protection to enter the room. LPN/LALD-A stated she did not post the precautions sign on the door of the resident rooms because she thought it would be a dignity concern. LPN/LALD-A indicated visitors would not know what PPE to apply before going into the rooms. LPN/LALD-A further stated PPE should be removed at the entryway of rooms upon exit, not in the hallway. The licensee's Initiating Transmission Based Isolation Precautions policy dated August 2020, indicated: 7. For residents requiring DROPLET precautions: a. Use standard precautions AND b. Instruct visitor to report to the nurse before entering resident's apartment. c. Resident should maintain special separation of 6 feet from other residents or visitors. d. Staff will wear appropriate PPE for droplet precautions (surgical mask and eye protection; goggles/face shield) before entering room. TIME PERIOD FOR CORRECTION: Two (2) days	0 510		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must	01620		

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01620	Continued From page 4 be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed ongoing resident reassessments that did not exceed 90 days for two of two residents (R2, 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect	01620		

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01620	Continued From page 5 a large portion or all of the residents). The findings include: R2 R2's service plan dated July 11, 2022, indicated R2 received services including assistance with blood sugars, edema wraps, and medication administration. R2's record included assessments dated July 16, 2024, October 16, 2024, and January 16, 2025. The October 16, 2024, assessment was 92 days after the last date of the assessment on July 16, 2024, thus exceeding 90 calendar days. In addition, the January 16, 2025, assessment was 92 days after the last date of the assessment on October 16, 2024, thus exceeding 90 calendar days. R1 R1's service plan dated May 10, 2024, indicated R1 received services including assistance with grooming, washing folds, changing briefs, assistance with back brace as needed, blood sugar checks, and medication administration. R1's record included assessments dated May 24, 2024, August 22, 2024, and November 22, 2024. The November 22, 2024, assessment was 92 days after the last date of the assessment on August 22, 2024, thus exceeding 90 calendar days. On February 4, 2025, at 1:24 p.m., licensed practical nurse/licensed assisted living director (LPN/LALD)-A stated R2 and R1's assessments were late as noted above. LPN/LALD-A indicated the nurse had been using a calendar month and not counting the actual days in between.	01620		

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01620	Continued From page 6 The licensee's Nursing Assessment: Initial and On-Going of Residents Under the Comprehensive Licensed Agency policy dated July 2020, noted: 3. The RN will re-assess each resident on an on-going basis and will revise the resident's service plan based on the resident's needs. The RN will determine the frequency of re-assessments based on the resident's needs, with the frequency between assessments not to exceed 90 days from the last date of the assessment. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prescription medications were kept in the original container bearing the prescription label for two of two residents (R4, R1), failed to ensure the prescription label matched the order (R4), and failed to ensure time sensitive medications had an opened date for one of one resident (R1).	01890		

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01890	Continued From page 7 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: R4 R4's diagnoses included dry eye syndrome and chronic pain. R4's service plan dated June 20, 2023, indicated R4 received assistance with medication administration. R4's prescriber orders dated July 5, 2024, included: - carboxymethylcellulose sodium (lubricating eye drop) 0.5% one drop to both eyes three times daily; and - menthol methyl salicylate external cream (Asperflex) (topical analgesic) apply to any muscle joint pain topically three times a day. R4's medication administration record (MAR) dated February 1, 2025, through February 5, 2025, included the medications as ordered above. On February 3, 2025, at 2:09 p.m., the surveyor observed unlicensed personnel (ULP)-C administer carboxymethylcellulose sodium 0.5% one drop to both of R4's eyes and apply Asperflex	01890		

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01890	Continued From page 8 to R4's upper left shoulder and neck. The eye drops lacked a date when opened and a box or label with instructions on it. The Asperflex had a label that directed to apply to R4's legs as needed (PRN). When interviewed at this time, ULP-C stated normally the eye drops were kept in a box that had a label. ULP-C was unable to find the box for R4's eye drops, stating the eye drops lacked a label and date when opened. In addition, ULP-C stated the label for R4's Asperflex did not match the MAR but she applied it R4's left shoulder and neck as this is where R4 requested it. R1 R1's diagnoses included diabetes. R1's service plan dated May 10, 2024, indicated R1 received assistance with medication administration. On February 4, 2025, at 8:15 a.m., the surveyor observed R1's medications with ULP-D in R1's apartment. The surveyor noted there was no label or open date on R1's NovoLog FlexPen (fast-acting insulin to lower glucose in the blood) and Lantus (long-acting insulin) pen. ULP-D stated the insulin pens were lacking both labels and dates when opened. ULP-D indicated normally the insulin pens were kept in a labeled plastic bag, and the insulin pens should be dated when opened. On February 5, 2025, at 9:19 a.m., clinical nurse supervisor (CNS)-B stated all medications should be kept in the original container bearing the original prescription label. CNS-B further stated insulin should be dated when opened and kept with original labeling that identified who the insulin was for and instructions for use. CNS-B indicated	01890		

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01890	Continued From page 9 the licensee had recently changed pharmacies and the lack of labeling may be a result of this. On February 5, 2025, at 12:53 p.m. CNS-B stated R4's Asperflex label was incorrect and did not match the prescriber order or MAR. CNS-B stated it was a pharmacy label error, but indicated staff should have brought it to her attention. The NovoLog FlexPen manufacturer instructions for use dated revised February 2023, indicated the NovoLog FlexPen should be thrown away after 28 days, even if it still has insulin left in it. The Lantus SoloStar manufacturer instructions for use dated revised December 2020, indicated once you take your SoloStar out of cool storage, you can use it for up to 28 days. The licensee's Storage of Medications policy dated September 2020, noted b. Until the medication is set up for immediate or later administration by a nurse, a legend drug must be kept in its original container bearing the original prescription label with legible information stating the prescription number, name of drug, strength and quantity of drug, expiration date of time-dated drug, directions for use, resident's name, prescriber's name, date of issue and the name and address of the licensed pharmacy that issued the medication. c. An over-the-counter drug must be kept in the original labeled container from the pharmacy or manufacturer. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

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01940 SS=E	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for two of two	01940		

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SACRED HEART ASSISTED LVG APTS	1202 12TH ST SW AUSTIN, MN 55912

(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
01940	Continued From page 11 residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a 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: During the entrance conference on February 3, 2025, at 11:07 a.m., licensed practical nurse/licensed assisted living director (LPN/LALD)-A stated the licensee provided treatment management services to their residents. R1 R1's diagnoses included diabetes. R1's service plan dated May 10, 2024, and updated care plan with a print date of February 4, 2025, indicated R1 received services including assistance with grooming, washing folds, changing briefs, assistance with back brace as needed, blood sugar checks, edema wraps, and medication administration. On February 3, 2025, at 2:31 p.m., the surveyor observed R1 wearing thromboembolic deterrent (TED) hose (compression socks used to increase circulation and reduce swelling in the legs). R1 stated staff apply the TED hose in the morning and remove at bedtime.	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20386	A. BUILDING: _____ B. WING _____	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SACRED HEART ASSISTED LVG APTS	1202 12TH ST SW AUSTIN, MN 55912

(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
01940	Continued From page 12 R1's prescriber orders dated January 9, 2025, included TED hose apply to bilateral lower extremities, on every morning and off at bedtime. R1's treatment administration record (TAR) dated February 1, 2025, through February 4, 2025, included documentation R1 had TED hose on in the morning and off at bedtime. R1's treatment plan dated January 9, 2025, and TAR dated February 1, 2025, through February 4, 2025, failed to include the following required content: - procedures for notifying a registered nurse when a problem arose with treatments or therapy services. R2 R2's diagnoses included diabetes. R2's service plan dated June 30, 2022, indicated R2 received assistance with blood sugar checks. R2's prescriber orders dated July 8, 2024, included blood sugar checks daily in the morning. R2's medication administration record (MAR) dated February 1, 2025, through February 4, 2025, included documentation of R2's blood sugar check daily in the morning before eating. R2's treatment plan dated August 1, 2023, and task list dated September 18, 2024, failed to include the following required content: - procedures for notifying a registered nurse when a problem arose with treatments or therapy services. On February 5, 2025, at 9:25 a.m., clinical nurse	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20386	A. BUILDING: _____ B. WING _____	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SACRED HEART ASSISTED LVG APTS	1202 12TH ST SW AUSTIN, MN 55912

(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
01940	Continued From page 13 supervisor (CNS)-B stated R1 and R2's record lacked a treatment management plan to include all the required content as noted above. CNS-B stated there should be specific blood sugar parameters for staff to follow for R2 and when to notify the nurse as well as specific reasons to notify the nurse with R1's TED hose. The licensee's Development of the Individualized Treatment and Therapy Plan and Individualized Treatment Administration Record policy dated June 2020, indicated the registered nurse would develop an individualized treatment and therapy management plan. The plan would contain at least the following: - procedures for notifying a registered nurse when a problem arises with treatments or therapy services. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		

Minnesota Department of Health
Environmental Health - FPLS

Rochester

Type: Full
Date: *02/03/25*
Time: 10:22:29
Report: 1038251014

Food and Beverage Establishment Inspection Report

Location:
Sacred Heart Assisted Lvg Apts
1202 12th St Sw
Austin, MN55912
Mower County, 50

Establishment Info:
ID #: 0038724
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5074331808
ID #:

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

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

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

Hot Water: = at Degrees Fahrenheit
Location:
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Freezer
Temperature: 10 Degrees Fahrenheit - Location: Ice Cream
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 34 Degrees Fahrenheit - Location: Milk
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 35 Degrees Fahrenheit - Location: Milk
Violation Issued: No

Process/Item: Upright Freezer
Temperature: 0 Degrees Fahrenheit - Location: Hotdogs
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 40 Degrees Fahrenheit - Location: Cheese Slices
Violation Issued: No

Type: Full
Date: *02/03/25*
Time: 10:22:29
Report: 1038251014
Sacred Heart Assisted Lvg Apts

Food and Beverage Establishment Inspection Report

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

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1038251014 of 02/03/25.

Certified Food Protection Manager: Brenda Sabin

Certification Number: FM16697 Expires: 05/23/27

Signed: _____
Establishment Representative

Signed: _____
Rob Davis
Sanitarian 2
Rochester District Office
507-810-9902
rob.davis@state.mn.us