Electronically Delivered

June 28, 2022

Administrator
Boulder Creek
604 Village Drive
Marshall, MN 56258

RE: Project Number(s) SL30908015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on June 2, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

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

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

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

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

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

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

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

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

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

Please address your cover letter for general reconsideration requests to:	Free from Maltreatment reconsideration requests should be addressed to:

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

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

REQUESTING A HEARING

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

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

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

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 507-344-2730 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30908	A. BUILDING: _____ B. WING _____	06/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOULDER CREEK	604 VILLAGE DRIVE MARSHALL, MN 56258

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#30908015 On, May 31, 2021, through June 2, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 29 residents, all of whom received services under the provider's Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared according to the Minnesota Food Code. This had the potential to affect all twenty-nine (29) residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: KITCHEN INSPECTION	0 480		

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0 480	Continued From page 2 Please refer to the additional documentation included in the "Food and Beverage Establishment Inspection Reports," dated June 1, 2022. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to establish and maintain an effective infection control program that complies with accepted health care, medical and nursing standards for infection control related to COVID-19, when they did not comply with MDH guidance for COVID-19 related to wearing appropriate PPE (personal protective equipment). This had the potential to affect all current residents, staff and visitors.	0 510		

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0 510	Continued From page 3 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: The licensee failed to ensure employees in direct contact with residents were wearing appropriate personal protective equipment (PPE) per the Centers for Disease Controls (CDC) and Minnesota Department of Health (MDH) guidelines. On May 31, 2022, at approximately 9:30 a.m. licensed assisted living director (LALD)-A greeted surveyors at the front entrance and was not wearing a surgical mask or eye protection. LALD-A escorted surveyors to a conference room, bypassing the table set up near the front entrance with guest sign-in sheet, surgical face masks, thermometer, and alcohol rub. On May 31, 2022, at approximately 12:00 p.m. during a tour with LALD-A, unlicensed personnel (ULP)-D was observed not to wear eye protection in the dining room with multiple residents present. On May 31, 2022, at approximately 12:25 p.m. during a tour with LALD-A, ULP-H was observed not to wear eye protection in the main dining area with two residents present. On May 31, 2022, at 2:05 p.m. activity assistant (AA)-E was wearing a face shield but no mask,	0 510		

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0 510	Continued From page 4	0 510		

and was assisting R4 to clean up some spilled water.

On May 31, 2022, at 2:11 p.m. ULP-H was observed wearing a face mask below her nose and no eye protection when ULP-H entered R2's room, washed her hands, put on gloves, prepared and administered medications to R2.

On May 31, 2022, at 2:21 p.m. ULP-F and AA-E were in the dining room assisting residents to the table and they were serving snacks. ULP-F wore a medical mask but no eye protections. AA-E was wearing a cloth mask and no eye protection.

On May 31, 2022, at 2:50 p.m. LALD-A was sitting next to R4 and visiting with her. At 2:56 p.m. LALD-A got up from the table and was walking through the common area. She stopped to visit and redirect R3. LALD-A wore a medical mask but failed to wear eye protection.

On May 31, 2022, at 3:02 p.m. ULP-D and ULP-G stated they were instructed to wear medical masks. Initially, when COVID-19 started, they wore eye protection, but when things settled down they were no longer required to wear it. If they have COVID-19 positive residents, they are then supposed to wear eye protection, medical mask, gown, and gloves when caring for those residents.

On May 31, 2022, at 4:13 p.m. registered nurse (RN)-B stated staff were to wear a medical grade face mask. Nursing staff did not wear eye protection unless caring for a COVID positive resident. Activity staff at times will wear a face shield without a face mask during an activity, as long as they were socially distanced. The staff initially wore eye protection but stopped

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0 510	Continued From page 5 approximately April 2021, after vaccinations had been completed. RN-B stated she was unaware of the current MDH and CDC guidelines for eye protection. On May 31, 2022, the CDC community transmission level for Lyon County was "high." MDH's COVID-19 PPE and Source Control Grids identified facilities were to wear a face mask and eye protection during high community transmission rates. The licensee's COVID-19 Staff Infection Control Precautions policy dated July 29, 2021, identified the following: "Masks - Home care staff will wear mask while working scheduled shift. - Surgical/procedural masks will be provided. For a circumstances outside of supervisor control of obtaining surgical masks. It may require the optimizing of the masks by reuse to prolong supply. - Optimizing masks; home care staff will have to don on mask at start of shift. Mark on paper bag number of use of mask. At end of shift, staff member will place mask in paper bag and store in designated area. After five uses staff will discard mask and paper bag. Staff member will receive a new mask and paper bag at start of next shift. - Mask would be donned at start of shift. If the mask is doffed at any part of shift. Mask will be place on a paper towel outside down. - Meticulous adherence to hand hygiene before and after removing face masks is expected. - Proper mask use is expected. Wear the mask as directed to cover nose and mouth, not wearing mask under chin or on top of head, not placing mask in pocket. - Staff encouraged avoidance of	0 510		

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0 510	Continued From page 6	0 510		

manipulation/touching of the mask.
- If staff need to change a mask because it becomes soiled, rips/tears or un breathable. Staff may go and get a new mask in the screening area. Staff is requested to sign mask out and reason a new one was needed. There is a shortage of masks, please be respectful of the supply. Supply is counted daily to monitor.
- Alternative/fabric masks will be initiated as part of the optimizing of masks plan.
-Care for alternative/fabric masks; wash reusable masks at least daily."
"Eye Protection
- Home care staff is required to wear eye protection during direct client care for clients who are suspected, or confirmed with COVID-19. Staff is to follow recommended face shield sanitizing before and after each use. Before shift, during shift such as breaks and after shift.
- Sanitizing face shield is as follows; using sanitizing spray and paper towel staff member will spray entire face shield front and back. Staff will wipe face shield starting back of face shield followed by wiping of the front of the face shield. Face shields will be kept in designated area when not being used.
- Staff will receive a new face shield/eye protection if the face shield is unable to be used due to shield breakdown or difficulty viewing through face shield. Soiled to the point of unable to be sanitized.
- Staff encouraged avoidance of manipulation/touching of the face shield.
- Meticulous adherence to hand hygiene before and after removing face shield is expected."

No further information was provided.

TIME PERIOD FOR CORRECTION: Seven (7) days

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0 650 SS=A	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (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 required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. 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 one of two employees (unlicensed personnel	0 650		

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0 650	Continued From page 8 (ULP)-D) with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at 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: ULP-D had a start date of September 24, 2021. On May 31, 2022, at 2:11 p.m. ULP-D was observed administering medications to R2. On June 1, 2022, at 11:37 a.m. ULP-D was observed administering medication to R1. ULP-D's employee file lacked evidence she had been competency tested for medication administration. On June 2, 2022, at 2:12 p.m. human resources (HR)-N stated the competency evaluations for ULP-D had been completed. The form was not in the employee file, and HR-N was not able to locate it. The Licensee's Personnel Records policy dated July 29, 2021, identified the personnel record would include a "record of all required training for unlicensed personnel and competency determinations." No further information was provided. TIME PERIOD FOR CORRECTION:	0 650		

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0 650	Continued From page 9 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 (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are 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 and have available a written emergency disaster plan with all required content outlined in Appendix Z. This had the potential to affect all current residents,	0 680		

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0 680	Continued From page 10 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: The licensee's Emergency Preparedness Manual Planning, Policy and Procedures binder undated, included general policies for various threats and a hazard risk assessment, which included threats such as fire, severe weather, flooding, bomb threat. The facility's plan lacked the following required content: - an assessment of the at risk population's needs; - policies and procedures that are stored in a central place; - process for emergency preparedness (EP) collaboration with state and local EP officials/organizations; - procedure for tracking staff and residents; - development of policies/procedures based on risk assessment to address: - the medical record documentation system to preserve resident information; - use of volunteers; - emergency staff strategies; and - the facility's role in providing care and treatment at alternative sites. - a communication plan that included: - arrangement with other facilities;	0 680		

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0 680	Continued From page 11 - names and contact information for resident physicians; - contact information for federal, state, tribal, local EP staff, or the ombudsman; - primary and alternative means for communicating with facility staff, or federal, state, regional and local emergency management agencies; - a method of sharing information and medical documentation for residents; - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy; and -a method of sharing information from the emergency plan with residents and their families. - EP training and testing program; - EP training program for staff (including documentation of training provided); - EP testing/annual testing requirements; and - how the facility will provide care under an 1135 waiver declared by the Secretary. In addition, a record review and interview was conducted on June 2, 2022, at approximately 1:40 p.m. with Maintenance Supervisor (MS)-M on the generator maintenance logs for the facility. A record review of the available documentation indicated that the licensee did not have records of required weekly inspection and maintenance of the emergency generator and required monthly load testing of the emergency generator as required by NFPA 110. During interview, MS-M indicated the licensee did not have any records to provide for review for compliance. On June 2, 2022, at 5:05 p.m., licensed assisted living director (LALD)-I confirmed the emergency preparedness plan lacked required content and needed more work to complete it.	0 680		

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0 680	Continued From page 12 No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of	0 810		

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0 810	Continued From page 13	0 810		

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 a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements, failed to provide required employee and resident training on fire safety and evacuation, and failed to conduct required evacuation drills. This had the potential to affect all staff, residents, and visitors.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).

Findings include:

A record review and interview were conducted on June 2, 2022, at approximately 1:40 p.m. with Maintenance Supervisor (MS)-M on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. A follow up interview was conducted on June 2, 2022, at approximately 4:00 p.m. with Licensed Assisted Living Director (LALD)-I.

Record review of the available documentation indicated that the licensee did not have employee actions to be taken in the event of a fire or similar emergency. During interview, MS-M stated that he does not know how to provide me with the

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0 810	Continued From page 14 requested documentation. In the follow up interview, LALD-I indicated that employee actions to be taken in the event of a fire were to remove the resident from danger and call 911 and did not prescribe any additional actions to be taken. Employee actions for other emergencies as required by statute were requested but were not able to be provided. LALD-I stated that the facility cannot plan for all scenarios under this requirement. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan. During interview, MS-M stated that he does not know how to provide me with the requested documentation. In the follow up interview, LALD-I stated that all residents were memory care and did not feel these procedures needed to be provided. Record review of the available documentation indicated that the fire safety and evacuation plan did not include 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. During interview, MS-M stated that he does not know how to provide me with the requested documentation. In the follow up interview, LALD-I provided documentation in the plan showing an ambulatory ability level grading for residents of one through four but did not show how these levels are assigned to residents. LALD-I stated that the staff should be aware of these levels from working with the resident and should be able to apply the levels themselves instead of directly identifying the unique and unusual needs of each resident.	0 810		

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0 810	Continued From page 15 Record review of available documentation indicated that the licensee did not provide employee training on the fire safety and evacuation plan twice per year after the training it initial hire. During interview, MS-M stated that he does not know how to provide me with the requested documentation. In the follow up interview, LALD-I stated that employee training happens either annually or twice per year but was unsure and could not provide a policy on this. Record review of the available documentation indicated that the licensee did not provide annual training to residents who can assist in their own evacuation on the proper actions to take in the event of a fire to include movement, evacuation, or relocation as required by statute. During interview, MS-M stated that he does not know how to provide me with the requested documentation. In the follow up interview, LALD-I indicated there was no resident training and was not able to provide a policy. Record review of the available documentation indicated that the licensee did not conduct evacuation drills every other month as required by statute. During interview, MS-M stated that he does not know how to provide me with the requested documentation. In the follow up interview, LALD-I provided drill sheets and stated that evacuation was not practiced at drills and that the sheets were only filled out after discussing protocols. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		

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0 970	Continued From page 16	0 970		
0 970 SS=F	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On May 31, 2022, at approximately 10:00 a.m. a copy of the provider's assisted living contract was requested. The licensee's Resident Agreement, identified as the assisted living contract, included two clauses that indicated the resident would waive the facility's liability for health, safety, or personal	0 970		

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0 970	Continued From page 17	0 970		

property of a resident.
"17. No Liability of Management
A. Personal Property of Resident: No Liability of Management. Management has no responsibility to Resident or any third party for any personal property placed on the premises by Resident or the owner of such personal property. Management is not responsible to Resident or any third party for loss of any personal property by theft or any other cause. Resident is encouraged to secure an room or renter's insurance policy to protect against such loss, if so desired.
B. No Liability of Management for Certain Other Losses or Damages. Management is not liable to Resident or to any other person for any loss, including personal injuries sustained by Resident or any other person, or any loss or damage to property, which is not the direct result of the intentional or negligent failure of Management to provide services under this Agreement. Management is not responsible for the actions of, or for any damages, injury or harm caused by, third parties (such as other Residents, guests, home care providers, intruders, or trespassers) who are not under Management's control."

The licensee's No Liability Policy dated January 19, 2017, identified the following:
"A. Personal Property of Tenant: No Liability of Management. Management has no responsibility to Tenant or any third party for any personal property placed on the premises by Tenant or the owner of such personal property. Management is not responsible to Tenant or any third party for loss of any personal property by theft or any other cause. Tenant is encouraged to secure an apartment or renter's insurance policy to protect against such loss, if so desired.
B. No Liability of Management for Certain Other

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0 970	Continued From page 18 Losses or Damages. Management is not liable to Tenant or to any other person for any loss, including personal injuries sustained by Tenant or any other person, or any loss or damage to property, which is not the direct result of the intentional or negligent failure of Management to provide services under this Agreement. Management is not responsible for the actions of, or for any damages, injury or harm caused by, third parties (such as other tenants, guests, home care providers, intruders, or trespassers) who are not under Management's control. This is a memory care facility so things may be borrowed, misplaced, on broken. There is a locked memory cabinet that things may be placed in if your loved one must be something of value. [The licensee] is not responsible for misplaced or broken items." On June 1, 2022, at 3:03 p.m. licensed assisted living director (LALD)-A confirmed the assisted living contract required residents to waive the facility's liability for health, safety, or personal property. LALD-A confirmed the same assisted living contract was used for all residents at the facility. In addition, residents received and signed the No Liability Policy. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living	01440		

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01440	Continued From page 19 facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure one of one unlicensed personnel (ULP-C) was supervised by a registered nurse (RN) within 30 days after providing delegated tasks with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	01440		

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01440	Continued From page 20 ULP-C had a hire date of February 23, 2022. On June 1, 2022, at approximately 9:20 a.m. ULP-C was observed to administer morning medications to R5. ULP-C's employee record lacked evidence of direct supervision within 30 days after beginning work and first performing delegated tasks. On June 2, 2022, at approximately 3:12 p.m. RN-B confirmed the 30-day supervision was not completed. The licensee's Supervision of the Unlicensed Personnel policy dated August 1, 2021, indicated that direct supervision of the unlicensed staff providing delegated nursing tasks, delegated treatments or assigned therapy tasks must be performed within 30 days after the person begins work for the agency and has been trained and determined competent to perform all the tasks assigned. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01650 SS=E	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services;	01650		

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01650	Continued From page 21 (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included the required content for two of three residents (R4, R5) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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:	01650		

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01650	Continued From page 22 R4 and R5 began receiving services under the assisted living licensure on August 1, 2021. R4 R4's Service Plan effective December 1, 2021, indicated R4's services included assistance with dressing, meals, showering, medication administration, escorts, and bathing. R4's service plan incorrectly indicated the schedule and methods of monitoring assessments of the resident to include the initial assessment would be completed within five days after initiation of home care services. R5 R5's Service Plan dated August 1, 2021, indicated R5's services included assistance with ambulation, bathing, dressing, escorts, medication administration, blood glucose, support stocking and skin care. R5's service plan incorrectly indicated the schedule and methods of monitoring assessments of the resident to include the initial assessment would be completed within five days after initiation of home care services. On June 1, 2022, at approximately 3:00 p.m. licensed assisted living director (LALD)-A confirmed the service plan contained the language from the old comprehensive licensure, regarding the schedule and methods of monitoring assessments of residents. The licensee's Service Plan Agreement policy dated July 29, 2021, indicated the service plan would include the schedule and methods of monitoring assessment of the resident.	01650		

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01650	Continued From page 23 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
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 time sensitive medications were dated when opened and had a pharmacy label for three of three residents (R8, R3, and R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a 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: R8 On June 1, 2022, at 11:15 a.m. a review of R8's	01890		

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01890	Continued From page 24	01890		

locked medication cabinet with unlicensed personnel (ULP)-H identified the following:
- timolol maleate 0.5% drops (eye drops to treat glaucoma) - the bottle did not have a pharmacy label, and it was stored outside of the box that contained the pharmacy label. Neither the bottle or the box had an open date.
- Latanoprost solution 0.005% drops (eye drops to treat glaucoma) - two open bottles, both with solution remaining. The bottles did not have a pharmacy label and they were stored outside of the boxes that contained the pharmacy label. Neither the bottles or the boxes had an open date.
- stomach relief bismuth subsalicylate mg (milligram) (for stomach upset) - half of a bottle without a pharmacy label. The manufacturer expiration date was September 2021.
ULP-H verified the eye drops should be stored in the boxes with the pharmacy labels.

R3
On June 1, 2022, at 11:31 a.m. a review of R3's locked medication cabinet with ULP-H identified the following:
- timolol maleate 0.5% drops were stored in the box with a pharmacy label. Neither the bottle or the box had an open date.
- a partial tube of Biofreeze (pain relief cream) with a manufacturer expiration date of September 16, 2021.

R1
On June 1, 2022, at 10:40 a.m. a review of R1's locked medication cabinet with ULP-H identified the following:
- fluticasone nasal spray (for allergies) - the bottle did not have a pharmacy label and it was stored outside of the box that contained the pharmacy label.

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01890	Continued From page 25 - Symbicort 160-4.5 mcg inhaler (helps breathing and lung function) - there was no open date on the inhaler. - Incruse Ellipta umeclidinium inhalation powder 62.5 mcg (micrograms) (treats chronic lung problems). There was no pharmacy label or open date on the inhaler. There was no box with a pharmacy label in the cabinet. On June 1, 2022, at approximately 11:45 a.m. ULP-H stated the staff did not mark the open dates on the bottles. The registered nurse (RN) was in charge of marking the bottles. The bottles were used until empty, unless it was expired according to the manufacturer's expiration date. On June 1, 2022, RN-B stated medications were to be stored in their original containers with a pharmacy label. The staff were to write the date opened on the container for mediations that were time sensitive. Medications were not to be used after expiration according to manufacturer recommendations. Timolol manufacturer directions dated January 2020, identified "you can use Timolol for 28 days after first opening the bottle. Discard the opened bottle with any remaining solution after that time." Latanoprost manufacturer directions dated September 16, 2014, identified "must be used within 28 days after opening the bottle. Discard the bottle and/or unused contents after 28 days." Symbicort manufacturer directions dated 2018, identified "Discard the inhaler when the arrow points to the red zone and reads zero (0) or 3 months after you take SYMBICORT out of its foil pouch, whichever comes	01890		

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	30908	A. BUILDING: _____ B. WING _____	06/02/2022

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01890	Continued From page 26 first." Incruse Ellipta manufacturer directions dated June 2019, identified : Safely throw away INCRUSE ELLIPTA in the trash 6 weeks after you open the tray or when the counter reads "0", whichever comes first. Write the date you open the tray on the label on the inhaler." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01910	Continued From page 27 by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of medications, including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition for one of one discharged resident (R6) with record review. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R6's Discharge Summary dated May 5, 2022, identified R6 was admitted on February 10, 2022. R6 received medication management services and assistance with activities of daily living. R6 was discharged on May 5, 2022, due to an inability to meet R6's needs. R6's medications were given to the resident's spouse upon discharge. R6's Disposition of Medications dated May 4, 2022, included the medication, strength, and quantity for the following medications: - acetaminophen (pain); - Biofreeze gel (pain) - vitamin D3 (supplement); - vitamin B-12 (supplement); - Aricept (dementia); - Midodrine (blood pressure);	01910		

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01910	Continued From page 28 - sertraline (depression); and - warfarin (blood thinner). The documentation lacked the pharmacy prescription numbers for these medications. On March 31, 2022, at 4:09 p.m. registered nurse (RN)-B confirmed the missing content and stated that all of the medication dispositions would be missing the required content of prescription numbers. She was unaware of the requirement. The licensee's Disposition or Disposal of Medication policy dated July 29 2021, identified "Staff will document in the client's record the name of the person to whom the medications were given, the time and date, the name of each medication and the amount of medication remaining." The policy did not identify the requirement of the pharmacy prescription number. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must	01940		

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01940	Continued From page 29 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 record to include all required content for one of three residents (R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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:	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01940	Continued From page 30 R3 R3's service plan dated January 10, 2022, did not include blood glucose monitoring. R3's Individualized Treatment and Therapy plan dated June 1, 2022, did not include blood glucose monitoring. R3's physician order dated March 10, 2022, identified "glucose checks fasting and stagger second time of day check. On June 1, 2022, at 3:07 p.m. registered nurse (RN)-B confirmed R3 received blood glucose monitoring twice daily. She confirmed blood glucose monitoring was not on the service plan or the Individualized Treatment and Therapy Plan. RN-B stated the blood glucose monitoring should be on the service plan, and she was unaware that it was not on it. The licensee's Content of Service Plans policy dated July 29, 2021, identified "Service plans will include: a. A description of the services provided b. Fees for services c. Frequency of each service according to resident assessment and resident preferences d. Schedule and methods of monitoring assessments e. Schedule and methods of monitoring staff providing services f. Contingency plan" No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01940		

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02040	Continued From page 31	02040		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property for the facility. This deficient practice had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on June 2, 2022, at approximately 1:40 p.m. with	02040		

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02040	Continued From page 32 Maintenance Supervisor (MS)-M on the hazard vulnerability assessment for the physical environment of the facility. A follow up interview was conducted on June 2, 2022, at approximately 4:00 p.m. with Licensed Assisted Living Director (LALD)-I. Record review of the available documentation indicated that the licensee had not performed a hazard vulnerability assessment with mitigation factors on and around the property. During interview, MS-M stated that he does not know how to provide me with the requested documentation. In the follow up interview, LALD-I stated that licensee had conducted a hazard vulnerability assessment for the emergency disaster plan for the facility but had not conducted a hazard vulnerability assessment of the physical environment with mitigation factors on and around the property to date at the time of survey. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02040		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are	02110		

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02110	Continued From page 33	02110		

person-centered and evidence-informed;
(3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes;
(4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications;
(5) staff training specific to dementia care;
(6) description of life enrichment programs and how activities are implemented;
(7) description of family support programs and efforts to keep the family engaged;
(8) limiting the use of public address and intercom systems for emergencies and evacuation drills only;
(9) transportation coordination and assistance to and from outside medical appointments; and
(10) safekeeping of residents' possessions.
(b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in.

This MN Requirement is not met as evidenced by:
Based on interview and record review, licensee failed to ensure policies and procedures required in the licensing of assisted living facilities with dementia care were developed, implemented, and provided to residents or responsible parties upon admission. This had the potential to affect all residents.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02110	Continued From page 34 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 failed to develop and implement policies and procedures that addressed: -philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; -evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; -wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; -medication management, including an assessment of residents for the use and effects of medication, including psychotropic medications; -staff training specific to dementia care; -description of life enrichment programs and how activities are implemented; -description of family support programs and efforts to keep the family engaged; -limiting the use of public address and intercom systems for emergencies and drills only; -transportation coordination and assistance to	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02110	Continued From page 35 and from outside medication appointments; and -safekeeping of resident's possessions. On June 2, 2022, at 5:27 p.m. licensed assisted living director (LALD)-A stated the licensee had not developed the required policies and procedures related to dementia care. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		

DEPARTMENT OF HEALTH

Type: Full
Date: *06/01/22*
Time: 11:04:00
Report: 1030221007

Food and Beverage Establishment Inspection Report

Location:
Boulder Creek
604 Village Drive
Marshall, MN56258
Lyon County, 42

Establishment Info:
ID #: 0038794
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5079291234
ID #:

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

The following orders were issued during this inspection.

3-500C Microbial Control: date marking

3-501.17B ** Priority 2 **

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.

Observed open gallon milk jugs in the north & south kitchens, Norlake upright coolers not date marked. PIC stated milk was opened this morning and will date mark with 06/01 date and will discard in 7 days if not used.

Comply By: 06/01/22

4-300 Equipment Numbers and Capacities

4-302.14 ** Priority 2 **

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

PIC stated they did not have test strips available to test concentration of the ProPower Quat sanitizer spray bottles located in each kitchen. Provide and use frequently to ensure a concentration of 200 ppm is maintained. Test strips left with PIC.

Comply By: 06/01/22

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

MN Rule 4626.1520A Clean and maintain all physical facilities clean.

Observed fans located in the kitchens with large amounts of dust, and accumulation of dirt and grease around and between the ice machines and dish washing machines in both kitchens. Clean all areas as often as necessary to keep clean.

Food and Beverage Establishment Inspection Report

Comply By: 06/03/22

Surface and Equipment Sanitizers

Quaternary ammonium: = 200 ppm at Degrees Fahrenheit
Location: Spray bottle south kitchen
Violation Issued: No

Quaternary ammonium: = 200 ppm at Degrees Fahrenheit
Location: Spray bottle north kitchen
Violation Issued: No

Hot water: = at 166.8 Degrees Fahrenheit
Location: NSF dish machine south kitchen
Violation Issued: No

Hot water: = at 170.1 Degrees Fahrenheit
Location: NSF dish machine north kitchen
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Noodles
Temperature: 174.4 Degrees Fahrenheit - Location: Hot holding unit
Violation Issued: No

Process/Item: Meat sauce
Temperature: 175.2 Degrees Fahrenheit - Location: Hot holding unit
Violation Issued: No

Process/Item: Creamed peas
Temperature: 201.5 Degrees Fahrenheit - Location: Hot holding oven
Violation Issued: No

Process/Item: Ambient
Temperature: 36.0 Degrees Fahrenheit - Location: Norlake upright cooler south kitchen
Violation Issued: No

Process/Item: Mrs. Gerry's Potato Salad
Temperature: 41.0 Degrees Fahrenheit - Location: Norlake upright cooler south kitchen
Violation Issued: No

Process/Item: Ambient
Temperature: 35.0 Degrees Fahrenheit - Location: Norlake upright cooler north kitchen
Violation Issued: No

Process/Item: crumble cooked bacon
Temperature: 38.4 Degrees Fahrenheit - Location: Norlake upright cooler north kitchen
Violation Issued: No

Process/Item: Ambient
Temperature: -10 Degrees Fahrenheit - Location: Norlake upright freezer south kitchen
Violation Issued: No

Type: Full
Date: *06/01/22*
Time: 11:04:00
Report: 1030221007
Boulder Creek

Food and Beverage Establishment Inspection Report

Process/Item: Ambient
Temperature: -12 Degrees Fahrenheit - Location: Norlake upright freezer north kitchen
Violation Issued: No

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

This was an inspection completed in conjunction with MDH Health Regulations Division (HRD) survey and requested by Stacy Haag, HRD team lead.

Background information:
Food is prepared and cooked in the Boulder Estates kitchen and transported in hot holding unit to assisted living facility kitchens where it is plated and served. Dishes, cups and utensils are sanitized in the assisted living kitchens. There are two kitchens located at this facility.

Violations were discussed with Margaret Sawchak, Dietary Manager/person in charge (PIC). Brian Harden, assisted living kitchen PIC, and Stacy Haag, HRD team lead.

Also the following was discussed:
Employee illness policy and log
Vomit/fecal incident clean up procedures
MN Certified Food Protection Manager & PIC requirements/duties
Food preparation (most same day service, but some complex with cook, cooling and reheat step)
Cooling procedures (foods prepared day before service and from ambient temperatures
Food temperatures
Thermometer use and calibration
Datemarking
Prevention of bare hand contact
Serving highly susceptible populations - using only pasteurized eggs and juice Cleaning and sanitizing food contact surfaces & dishes and utensils
Sanitizer use and test kit

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

I acknowledge receipt of the inspection report number 1030221007 of 06/01/22.

Certified Food Protection Manager: Cathy E. Hutchins

Certification Number: FM87429 Expires: 01/28/23

Inspection report reviewed with person in charge and emailed.

Signed: _____
Margaret Sawchak
Dietary Manager

Signed: Denise Schumacher
Denise Schumacher

Marshall DO
denise.schumacher@state.mn.us

Report #: 1030221007

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

No. of RF/PHI Categories Out	1	Date	06/01/22
No. of Repeat RF/PHI Categories Out	0	Time In	11:04:00
Legal Authority MN Rules Chapter 4626		Time Out	

	Address	City/State	Zip Code	Telephone
Boulder Creek	604 Village Drive	Marshall, MN	56258	5079291234

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0038794		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

			COS	R
Safe Food and Water				
30		IN OUT N/A Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32		IN OUT N/A Variance obtained for specialized processing methods		
Food Temperature Control				
33		Proper cooling methods used; adequate equipment for temperature control		
34		IN OUT N/A N/O Plant food properly cooked for hot holding		
35		IN OUT N/A N/O Approved thawing methods used		
36		Thermometers provided & accurate		
Food Identification				
37		Food properly labled; original container		
Prevention of Food Contamination				
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
Proper Use of Utensils				
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
Utensil Equipment and Vending				
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48	X	Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55	X	Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 06/02/22

Inspector (Signature) Denise Schmidt