Electronically Delivered

March 19, 2024

Licensee
Adapta
2020 5th Street Southwest
Rochester, MN  55902

RE:  Project Number(s) SL33762015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 21, 2024, 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 . . ."

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

**DOCUMENTATION OF ACTION TO COMPLY**

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

The correction order documentation should include the following:

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

**CORRECTION ORDER RECONSIDERATION PROCESS**

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by 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**

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 |
|---|---|---|---|
| | 33762 | A. BUILDING: _____ B. WING _____ | 02/21/2024 |

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| ADAPTA | 2020 5TH STREET SW ROCHESTER, MN 55902 |

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| 0 000 | Initial Comments<br><br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.<br><br>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.<br><br>INITIAL COMMENTS:<br>SL33762015<br><br>On February 20, 2024, through February 21, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 18 residents; 18 receiving services under the Assisted Living license. | 0 000 | Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>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. | |
| 0 550 SS=F | 144G.41 Subd. 7 Resident grievances; reporting maltreatment<br><br>All facilities must post in a conspicuous place | 0 550 | | |

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| 0 550 | Continued From page 1<br><br>information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to post in a conspicuous place, information about the licensee's grievance procedure with the required content. This had the potential to affect the licensee's current residents, staff, and visitors.<br><br>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).<br><br>The findings include:<br><br>On February 20, 2024, at 9:55 a.m. during the facility tour with licensed assisted living director | 0 550 | | |

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| 0 550 | Continued From page 2<br><br>(LALD)-A, the surveyor observed the licensee's grievance procedure posted by the front door of the facility. Though the posted grievance procedure included the contact information for the Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, and the person responsible for handling resident grievances, the posting lacked information regarding the Minnesota Adult Abuse Reporting Center (MAARC).<br><br>On February 21, 2024, at 8:22 a.m., LALD-A reviewed the posted grievance procedure and stated it did not include information regarding MAARC.<br><br>No additional information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 550 | | |
| 0 660 SS=D | 144G.42 Subd. 9 Tuberculosis prevention and control<br><br>(a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. | 0 660 | | |

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| 0 660 | Continued From page 3<br><br>(b) The facility must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included documentation of a completed health history and symptom screening for one of two employees (unlicensed personnel (ULP)-C).<br><br>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).<br><br>The findings include:<br><br>ULP-C was hired March 27, 2018, to provide direct care and services to the facility's residents.<br><br>ULP-C's employee record contained a negative quantiferon test dated April 20, 2018; however, ULP-C's employee record lacked evidence of TB history and symptom screening.<br><br>On February 20, 2024, at 12:51 p.m., operations director (OD)-E stated ULP-C's record lacked a TB history and symptom screening.<br><br>The licensee's TB Prevention and Control policy dated January 1, 2023, indicated upon hire staff | 0 660 | | |

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| 0 660 | Continued From page 4<br>would be screened for TB symptoms and tested for TB.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 660 | | |
| 0 780 SS=F | 144G.45 Subd. 2 (a) (1) Fire protection and physical environment<br><br>(a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:<br><br>(1) for dwellings or sleeping units, as defined in the State Fire Code:<br>(i) provide smoke alarms in each room used for sleeping purposes;<br>(ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms;<br>(iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics;<br>(iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and<br>(v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;<br><br>This MN Requirement is not met as evidenced by: | 0 780 | | |

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| 0 780 | Continued From page 5<br><br>Based on observation and interview, the licensee failed to provide interconnected smoke alarms that complied with fire protection requirements. This had the potential to directly affect all residents, staff, and visitors.<br><br>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).<br><br>The findings include:<br><br>On February 23, 2024, at 12:45 p.m., survey staff toured the facility with licensed assisted living director (LALD)-A. During the tour, survey staff observed when smoke alarms were tested in resident bedrooms 6 and 9 in the north wing, none of the other smoke alarms in the dwelling unit were activated. The smoke alarms installed in the bedrooms and outside each sleeping area were not all interconnected. On February 23, 2024, at 12:45 p.m., the smoke alarm test results were verified by LALD-A during the facility tour interview.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 780 | | |
| 0 790 SS=F | 144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment<br><br>(2) install and maintain portable fire extinguishers in accordance with the State Fire Code; | 0 790 | | |

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| 0 790 | Continued From page 6<br><br>(3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to maintain the portable fire extinguishers as required by statute. This deficient condition had the potential to affect all residents, staff, and visitors.<br><br>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).<br><br>The findings include:<br><br>On February 20, 2024, at 1:10 p.m., survey staff toured the facility with licensed assisted living director (LALD)-A. During the tour, survey staff observed one monthly inspection recorded during February 2024 on the back of the tags attached to the portable fire extinguishers. Fire extinguisher inspections must be conducted every month to ensure each extinguisher is in its designated place, it has not been tampered with, and there is no obvious physical damage or | 0 790 | | |

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| 0 790 | Continued From page 7<br><br>condition that would interfere with its use or operation. On February 20, 2024, during the facility tour interview, LALD-A verified fire extinguisher inspections had not been completed at the required frequency.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 790 | | |
| 0 810 SS=F | 144G.45 Subd. 2 (b)-(f) Fire protection and physical environment<br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:<br>(1) location and number of resident sleeping rooms;<br>(2) employee actions to be taken in the event of a fire or similar emergency;<br>(3) fire protection procedures necessary for residents; and<br>(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.<br>(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.<br>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.<br>(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.<br>(f) Evacuation drills are required for employees | 0 810 | | |

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| 0 810 | Continued From page 8<br><br>twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, record review, and interview, the licensee failed to develop a fire safety and evacuation plan with the required content, and provide required training. This had the potential to directly affect all residents, staff, and visitors.<br><br>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 potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>On February 20, 2024, at 1:10 p.m., survey staff toured the facility with licensed assisted living director (LALD)-A. During the tour, survey staff observed the resident room numbers were not legible on the fire evacuation floor plans posted in the facility. On February 20, 2024, during the facility tour interview, LALD-A verified the location and number of resident sleeping rooms were not clearly identified.<br><br>On February 20, 2024, licensed assisted living director (LALD)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety | 0 810 | | |

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| 0 810 | Continued From page 9<br><br>and evacuation training, and employee evacuation drills for the facility.<br><br>TRAINING<br>Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and/or at least twice per year as evident by the lack of training documentation to support this training had been completed. During an interview with survey staff on February 20, 2024, at 2:45 p.m., LALD-A stated employees were trained upon hire and annually on the FSEP, and additional training for fire safety and evacuation was completed with an online training provider. LALD-A verified records were not available to support employee FSEP training.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 810 | | |
| 0 970 SS=C | 144G.50 Subd. 5 Waivers of liability prohibited<br><br>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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident. This had the potential to | 0 970 | | |

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| 0 970 | Continued From page 10<br>affect all residents.<br><br>This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>The licensee's assisted living contract included a clause that indicated the resident would waive the licensee's liability for health, safety, or personal property of a resident.<br>-Page 14 of the contract indicated:<br>"Indemnification: Resident will indemnify and hold harmless Provider, its employees and agents from and against any and all claims, actions, damages, and liability and expense in connection with loss of life, personal injury or damage to property, arising from or out of the use by Resident of the rented premises or any other part of Provider's property, or caused wholly or in part by an act or omission of Resident or Resident's guest or agents".<br><br>On February 21, 2024, at 9:06 a.m. licensed assisted living director (LALD)-A stated the licensee's contract included the above content, and further stated the same contract was utilized for all residents at the facility.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 970 | | |

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| 01370 | Continued From page 11 | 01370 | | |
| 01370 SS=D | 144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn<br><br>(a) Training and competency evaluations for all unlicensed personnel must include the following:<br>(1) documentation requirements for all services provided;<br>(2) reports of changes in the resident's condition to the supervisor designated by the facility;<br>(3) basic infection control, including blood-borne pathogens;<br>(4) maintenance of a clean and safe environment;<br>(5) appropriate and safe techniques in personal hygiene and grooming, including:<br>(i) hair care and bathing;<br>(ii) care of teeth, gums, and oral prosthetic devices;<br>(iii) care and use of hearing aids; and<br>(iv) dressing and assisting with toileting;<br>(6) training on the prevention of falls;<br>(7) standby assistance techniques and how to perform them;<br>(8) medication, exercise, and treatment reminders;<br>(9) basic nutrition, meal preparation, food safety, and assistance with eating;<br>(10) preparation of modified diets as ordered by a licensed health professional;<br>(11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family;<br>(12) awareness of confidentiality and privacy;<br>(13) understanding appropriate boundaries between staff and residents and the resident's family;<br>(14) procedures to use in handling various emergency situations; and | 01370 | | |

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| 01370 | Continued From page 12<br><br>(15) awareness of commonly used health technology equipment and assistive devices.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview, and record review, the licensee failed to ensure training and competency was completed for one of two employees (unlicensed personnel (ULP)-D) to include all required content.<br><br>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).<br><br>The findings include:<br><br>ULP-D was hired on October 11, 2023, to provide direct care and services to the facility's residents.<br><br>ULP-D's employee record lacked evidence of training for the following topics:<br>-maintenance of clean and safe environment;<br>-training on the prevention of falls;<br>-basic nutrition, meal preparation, food safety, and assistance with eating;<br>-preparation of modified diets as ordered by a licensed health professional;<br>-communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; and<br>-understanding appropriate boundaries between staff and residents and the resident's family | 01370 | | |

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| 01370 | Continued From page 13<br><br>On February 20, 2024, at 2:50 p.m. operations director (OD)-E stated ULP-D was assigned the required training listed above via Educare (an online training program) but had not completed them.<br><br>The licensee's Assisted Living Orientation- ULP Staff policy dated August 1, 2021, indicated training and competency evaluations for ULP would include the following:<br>-maintenance of clean and safe environment<br>-fall prevention<br>-basic nutrition<br>-meal preparation<br>-food safety<br>-preparation of modified diets as ordered by a licensed health professional<br>-communication skills including preserving dignity of the resident, showing respect for the resident, resident preferences, cultural background, and family<br>-appropriate boundaries between staff, residents, and resident families<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01370 | | |
| 01380 SS=D | 144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn<br><br>(b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include:<br>(1) observing, reporting, and documenting resident status;<br>(2) basic knowledge of body functioning and | 01380 | | |

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| 01380 | Continued From page 14<br><br>changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel;<br>(3) reading and recording temperature, pulse, and respirations of the resident;<br>(4) recognizing physical, emotional, cognitive, and developmental needs of the resident;<br>(5) safe transfer techniques and ambulation;<br>(6) range of motioning and positioning; and<br>(7) administering medications or treatments as required.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure training and competency was completed for one of two employees (unlicensed personnel (ULP)-D) to include all required content.<br><br>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).<br><br>The findings include:<br><br>ULP-D was hired on October 11, 2023, to provide direct care and services to the facility's residents.<br><br>ULP-D's employee record lacked evidence of training for the following topics:<br>-basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to | 01380 | | |

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| 01380 | Continued From page 15<br><br>appropriate personnel; and<br>-recognizing physical, emotional, cognitive, and developmental needs of the resident<br><br>On February 20, 2024, at 2:50 p.m., operations director (OD)-E stated ULP-D was assigned the required training listed above via Educare (an online training program) but had not completed them.<br><br>The licensee's Assisted Living Orientation- ULP Staff policy dated August 1, 2021, indicated training and competency evaluations for ULP would include but not limited to the following:<br>-basic knowledge of body functioning, changes in body functioning, injuries or other observed changes that must be reported to appropriate personnel; and<br>-recognizing physical, emotional, cognitive and developmental needs of the resident<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01380 | | |
| 01470 SS=D | 144G.63 Subd. 2 Content of required orientation<br><br>(a) The orientation must contain the following topics:<br>(1) an overview of this chapter;<br>(2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person;<br>(3) handling of emergencies and use of emergency services;<br>(4) compliance with and reporting of the maltreatment of vulnerable adults under section | 01470 | | |

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| 01470 | Continued From page 16<br>626.557 to the Minnesota Adult Abuse Reporting Center (MAARC);<br>(5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;<br>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person;<br>(7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints;<br>(8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and<br>(9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure.<br>(b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:<br>(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication;<br>(2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or<br>(3) information about strategies and technology that may enhance communication and | 01470 | | |

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| 01470 | Continued From page 17<br><br>involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure one of two employees (unlicensed personnel (ULP)-D) received orientation to assisted living facility licensing requirements and regulations before providing services.<br><br>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).<br><br>The findings include:<br><br>ULP-D was hired on October 11, 2023, to provide direct care and services to the facility's residents.<br><br>ULP-D's Educare (an online training program) transcript indicated ULP-D had been assigned the "Person-centered care principles" course on October 11, 2023, but had not completed it.<br><br>ULP-D's employee record did not include the following required orientation content:<br>-the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. | 01470 | | |

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| 01470 | Continued From page 18<br><br>On February 20, 2024, at 2:50 p.m. operations director (OD)-E stated ULP-D was assigned the required training but had not completed it yet.<br><br>The licensee's Assisted Living Orientation- All Staff policy dated August 1, 2021, indicated all employees would complete an orientation to assisted living which included principles of person-centered planning and service delivery and how they apply to direct support services.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days. | 01470 | | |
| 01530 SS=D | 144G.64 TRAINING IN DEMENTIA CARE REQUIRED<br><br>(a) All assisted living facilities must meet the following training requirements:<br>(1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter;<br>(2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor | 01530 | | |

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| 01530 | Continued From page 19<br><br>meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter;<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure one of two employees (unlicensed personnel (ULP)-D) received the required amount of dementia care training in the required time frame.<br><br>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).<br><br>The findings include:<br><br>The licensee provided services under an Assisted Living license.<br><br>ULP-D was hired on October 11, 2023, to provide direct care and services to the facility's residents.<br><br>ULP-D's employee record lacked evidence of completing any dementia care training.<br><br>On February 20, 2024, at 2:50 p.m. operations director (OD)-E stated ULP-D was assigned dementia care training but had not completed it yet. | 01530 | | |

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| 01530 | Continued From page 20<br><br>The licensee's Assisted Living Dementia Training policy dated August 1, 2021, indicated direct care staff would complete a minimum of eight hours of initial training on dementia care topics. This initial training would be completed within 160 working hours of the employment start date.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 01530 | | |
| 01620 SS=D | 144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring<br><br>(c) Resident reassessment and monitoring must 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.<br>(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.<br>(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 | 01620 | | |

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| 01620 | Continued From page 21<br>resident moves in, whichever is earlier.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing nursing assessments not to exceed 90 days for one of two residents (R1).<br><br>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).<br><br>The findings include:<br><br>R1 was admitted on August 9, 2018, with diagnoses that included traumatic brain injury (TBI) with residual severe mobility and cognitive deficits.<br><br>R1's service plan dated February 15, 2023, indicated R1 received assistance with grooming, dressing, bathing, activity and meal assistance, ambulation/exercise, toileting, and medication management.<br><br>R1's ongoing nursing assessments were requested. Assessments dated August 28, 2023, November 21, 2023, and February 20, 2024, were provided.<br><br>The February 20, 2024, assessment was done 91 days after the date of the previous assessment, | 01620 | | |

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| 01620 | Continued From page 22<br>exceeding 90 calendar days.<br><br>On February 21, 2024, at 7:48 a.m. registered nurse (RN)-B stated R1's February assessment exceeded 90 days from the previous assessment.<br><br>The licensee's Initial and On-Going Nursing Assessments of Residents policy dated August 1, 2021, indicated ongoing assessments would be completed periodically but no less than every 90 days.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01620 | | |
| 01770 SS=F | 144G.71 Subd. 9 Documentation of medication setup<br><br>Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup included all the required content for the licensee's one resident (R4) with medication setup services.<br><br>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 | 01770 | | |

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| 01770 | Continued From page 23<br><br>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).<br><br>The findings include:<br><br>R4's diagnoses included traumatic brain injury.<br><br>On February 20, 2024, at 11:29 a.m. the surveyor observed unlicensed personnel (ULP)-C administer medications to R4 including one capsule of Probiotic-10 from a pre-filled weekly medication box.<br><br>R4's service plan dated January 26, 2024, indicated R4 received medication administration. R4's service plan did not include medication set up.<br><br>R4's signed physician orders dated June 16, 2023, included Probiotic-10 25 billion; take one capsule by mouth twice daily for gut health.<br><br>R4's record lacked documentation by the licensed nurse at the time of setup to include the name of medication, quantity of dose, times to be administered, and route of administration.<br><br>On February 20, 2024, at 1:19 p.m. registered nurse (RN)-B stated the medication set up for R4's one medication was not documented as required.<br><br>No further information was provided.<br><br>TIME PERIOD TO CORRECT: Seven (7) Days | 01770 | | |

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| 01810 | Continued From page 24 | 01810 | | |
| 01810 SS=F | 144G.71 Subd. 12 Medications; over-the-counter drugs; dietary<br><br>An assisted living facility providing medication management services for over-the-counter drugs or dietary supplements must retain those items in the original labeled container with directions for use prior to setting up for immediate or later administration. The facility must verify that the medications are up to date and stored as appropriate.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure over-the-counter (OTC) drugs were labeled with directions for use prior to setting up for immediate or later administration.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>R4<br>R4's diagnoses included traumatic brain injury.<br><br>R4's service plan dated January 26, 2024, indicated R4 received assistance with medication management.<br><br>On February 20, 2024, at 11:29 a.m. the surveyor | 01810 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 33762 | A. BUILDING: _____ B. WING _____ | 02/21/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ADAPTA | 2020 5TH STREET SW ROCHESTER, MN 55902 |

| (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 |
|---|---|---|---|---|
| 01810 | Continued From page 25<br><br>observed unlicensed personnel (ULP)-C prepare medications for R4. ULP-C removed an unlabeled bottle of Probiotic-10 and a weekly medication box from the refrigerator. ULP-C removed one capsule from the prefilled weekly medication box and placed it with R4's medications. ULP-C stated the unlabeled Probiotic-10 bottle was R4's and the ULP would either remove a capsule from the medication box or the bottle to administer it to R4. The surveyor inquired how they knew the bottle was R4's without a name or label on it, and ULP-C stated R4 was the only resident who received that medication.<br><br>On February 20, 2024, at 1:19 p.m. registered nurse (RN)-B stated the bottle of Probiotic was R4's and should have been labeled upon receipt of the medication.<br><br>STOCK MEDICATIONS FOR STANDING HOUSE ORDERS<br><br>On February 20, 2024, at 1:00 p.m. the surveyor observed the contents in the medication cupboard that stored the licensee's bulk standing house order medications and verified the contents with ULP-C. The surveyor noted two envelopes with medications in them, one was labeled "Tylenol 12 pills" and the second envelope was labeled "ibuprofen 12 pills". ULP-C stated the envelopes were sent along on resident outings, in case any of the residents had pain. ULP-C stated they would look up the specific orders for the resident via their electronic health records (EHR) on the devices they carried with them.<br><br>On February 20, 2024, at 1:19 p.m. RN-B stated she would set up these medications before an | 01810 | | |

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|---|---|---|---|
| | 33762 | A. BUILDING: _____ B. WING _____ | 02/21/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| ADAPTA | 2020 5TH STREET SW ROCHESTER, MN 55902 |

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|---|---|---|---|---|
| 01810 | Continued From page 26<br><br>activity so the staff could administer them to a resident if they had any pain or discomfort while out. RN-B further stated she did not document the setup of these medications or label them with resident names because any resident that went on the outing could use them. RN-B further stated the envelopes did not include directions for use because the prescriber orders could be different depending on which resident needed the medications.<br><br>The licensee's Storage of Medications policy dated August 1, 2021, indicated an OTC medication would be kept in the original labeled container from the pharmacy or manufacturer. It further stated until the medication is set up for immediate or later administration by a nurse, a legend drug would 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 and issue and the name and address of the licensed pharmacy that issued the medications.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01810 | | |
| 01890 SS=D | 144G.71 Subd. 20 Prescription drugs<br><br>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 | 01890 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 33762 | A. BUILDING: _____ B. WING _____ | 02/21/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| ADAPTA | 2020 5TH STREET SW ROCHESTER, MN 55902 |

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|---|---|---|---|---|
| 01890 | Continued From page 27<br>drug.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure time sensitive medications had an opened date for one of one resident (R2) and failed to identify and dispose of an expired medication for one of one resident (R2).<br><br>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).<br><br>The findings include:<br><br>R2's diagnoses included diabetes.<br><br>R2's service plan dated January 12, 2024, indicated R2 received assistance with blood sugar checks and medication administration.<br><br>On February 20, 2024, at 1:05 p.m. the surveyor observed the contents of the refrigerator in the medication room and verified the contents with unlicensed personnel (ULP)-C. The surveyor noted there was no open date on R2's Victoza pen and Basaglar Kwik pen (both insulin pens). ULP-C confirmed the insulin pens were not dated when opened then checked the insulin level on both pens and stated they had both been used. ULP-C further stated she was not aware that insulin should be dated when opened. | 01890 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 33762 | A. BUILDING: _____ B. WING _____ | 02/21/2024 |

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| ADAPTA | 2020 5TH STREET SW ROCHESTER, MN 55902 |

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| 01890 | Continued From page 28<br><br>On February 20, 2024, at 1:19 p.m. registered nurse (RN)-B stated insulin should be dated when opened.<br><br>The Victoza Instructions for use dated July 2023, indicated the insulin pen could be used for 30 days after the initial use of the pen.<br><br>The Basaglar Kwikpen instructions for use dated August 26, 2022, indicated to throw away an opened insulin pen after using it for 28 days, even if there is still insulin left in it.<br><br>EXPIRED MEDICATION<br><br>R2's medication administration record (MAR) dated February 2024, indicated R2 received Nicotine lozenges 4 milligrams (mg); dissolve one lozenge (4 mg) every two hours as needed for smoking cessation.<br><br>On February 20, 2024, at 1:10 p.m. the surveyor observed the contents of the medication cart and verified the contents with ULP-C. R2's bottle of Nicotine lozenges was noted and had an expiration date of October 2023. ULP-C stated the nurse usually checked the medication for expired medications and removed them as needed.<br><br>On February 20, 2024, at 1:19 p.m. RN-B stated R2's Nicotine lozenges should have been removed from the medication cart. RN-B stated she went through the cart to look for expired medications but must have missed this one and removed the expired medication from the medication cart. | 01890 | | |

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| 01890 | Continued From page 29<br><br>The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy dated August 1, 2021, indicated:<br>2. Medications, treatment and therapy always need to be administered according to the "6 rights" of administration:<br>A. Right Person<br>B. Right Medication, treatment or therapy<br>C. Right time<br>D. Right route (by mouth, eye drops, to the skin, etc.)<br>E. Right dose (how many milligrams, drops, etc.)<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01890 | | |
| 01900 SS=F | 144G.71 Subd. 21 Prohibitions<br><br>No prescription drug supply for one resident may be used or saved for use by anyone other than the resident.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to ensure a medication prescribed for one resident was not used for another resident.<br><br>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). | 01900 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 33762 | A. BUILDING: _____ B. WING _____ | 02/21/2024 |

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| ADAPTA | 2020 5TH STREET SW ROCHESTER, MN 55902 |

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| 01900 | Continued From page 30<br><br>The findings include:<br><br>On February 20, 2024, at 1:00 p.m. the surveyor observed the contents in the medication cupboard that stored the licensee's bulk standing house order medications and verified the contents with unlicensed personnel (ULP)-C. The surveyor noted one bottle of polyethylene glycol 17 grams with a piece of tape on the cap with a resident's name on it. At this time, the surveyor inquired if the resident's medication was used for other residents. ULP-C stated the resident switched to individual packets of polyethylene glycol so instead of wasting what was left in the bottle of polyethylene they saved it to use for the standing house orders since it was the same medication and dose.<br><br>On February 20, 2024, at 1:19 p.m. registered nurse (RN)-B stated she was unaware that a resident's medication was being used for administering standing house orders and any medications unused by a resident were to be destroyed by the nurse.<br><br>The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy dated August 1, 2021, indicated:<br>2. Medications, treatment and therapy always need to be administered according to the "6 rights" of administration:<br>A. Right Person<br>B. Right Medication, treatment or therapy<br>C. Right time<br>D. Right route (by mouth, eye drops, to the skin, etc.)<br>E. Right dose (how many milligrams, drops, etc.) | 01900 | | |

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| ADAPTA | 2020 5TH STREET SW ROCHESTER, MN 55902 |

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| 01900 | Continued From page 31<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01900 | | |
| 02310 SS=F | 144G.91 Subd. 4 (a) Appropriate care and services<br><br>(a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure care and services were provided according to acceptable health care and medical or nursing standards for the licensee's one resident (R1) with side rails.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>R1 was admitted on August 9, 2018, with diagnoses that included traumatic brain injury (TBI) with residual severe mobility and cognitive deficits. | 02310 | | |

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| 02310 | Continued From page 32<br><br>R1's service plan dated February 15, 2023, indicated R1 received assistance with grooming, dressing, bathing, activity and meal assistance, ambulation/exercise, toileting, and medications management.<br><br>On February 20, 2024, at 12:28 p.m. R1's room was observed to have a hospital bed with bilateral upper side rails. R1 stated he used the side rails to aid in getting in and out of bed and turning on his side while laying down.<br><br>R1's comprehensive assessment dated February 20, 2024, indicated R1 utilized a hospital bed with bilateral siderails to aid in transfers to and from bed, and turning and repositioning in bed. It also indicated R1 had been educated on the risks and benefits of using side rails. The assessment lacked documentation of the measurements of the side rails zones one through four.<br><br>On February 21, 2024, at 7:50 a.m. registered nurse (RN)-B stated R1's comprehensive assessment did not include zone measurements for R1's side rails.<br><br>On February 21, 2024, at 8:19 a.m. licensed assisted living director (LALD)-A stated the licensee did not measure the side rail zones and instead went off the measurements listed in the manufacturer directions.<br><br>The Food and Drug Administration's (FDA), A Guide to Bed Safety, dated 2000, and revised April 2010, indicated following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems | 02310 | | |

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| 02310 | Continued From page 33<br><br>with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe."<br>The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (within the rail) should not exceed 4 and 3/4 inches, zone 2 (under the rail, between rail supports or next to a single rail support) should not exceed 4 and 3/4 inches, zone 3 (between the rail and the mattress), should not exceed 4 and 3/4 inches, and zone 4 (under the rail, at the ends of the rail) should not exceed 2 and 3/8 inches or be greater than a 60 degree angle.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Two (2) Days | 02310 | | |

Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *02/21/24*
Time: 08:59:55
Report: 8044241049

# Food and Beverage Establishment Inspection Report



**Location:**
Adapta
2020 5th Street Sw
Rochester, MN55902
Olmsted County, 55

**Establishment Info:**
ID #: 0037974
Risk:
Announced Inspection: Yes

**License Categories:**

Expires on: / /

**Operator:**

Phone #: 5072880868
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**

Chlorine: = at 163.3 Degrees Fahrenheit
Location: Dishwasher
Violation Issued: No

**Food and Equipment Temperatures**

Process/Item: Cold Holding
Temperature: 39.7 Degrees Fahrenheit - Location: Upright
Violation Issued: No

Process/Item: Receiving
Temperature: 42.4 Degrees Fahrenheit - Location: Milk
Violation Issued: No

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

HRD inspection conducted with nurse evaluator Kassie Marking. Report reviewed on site with Kasi Haglund.

Facility consists of two serving kitchens with laminate counters, wooden hollow base cabinets, vinyl floors and painted gypsum walls, and a main kitchen with a commercial dishwasher. All food is catered in from Shorewood Senior Campuses.

Type: Full
Date: *02/21/24*
Time: 08:59:55
Report: 8044241049
Adapta

# Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 8044241049 of 02/21/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Signed:_____
Inspector signed for Kasi

Signed:_____
Michael DeMars, RS
Public Health Sanitarian III
Rochester District Office
507-216-1096
michael.demars@state.mn.us