DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

September 20, 2022

Administrator
Compassionate Cottage II
1506 Upper Trentwood Circle Northeast
Willmar, MN 56201

RE: Project Number(s) SL32777015

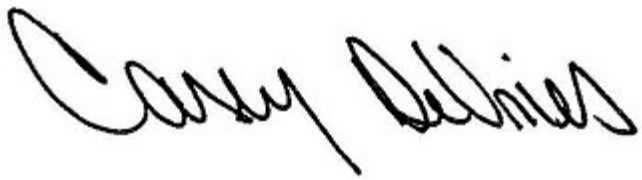
Dear Administrator:

On September 15, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the July 13, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-5917 Fax: 651-215-9697

PMB

Electronically Delivered

August 8, 2022

Administrator
Compassionate Cottage II
1506 Upper Trentwood Circle Northeast
Willmar, MN 56201

RE: Project Number SL32777015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on July 13, 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

St - 0 - 2310 - 144g.91 Subd. 4 - Appropriate Care And Services - $3,000.0

The total amount you are assessed is $3,500.00. 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:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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

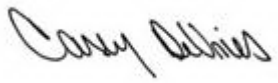
REQUESTING A HEARING

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,



Casey DeVries, Supervisor
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State Evaluation Team
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HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32777	A. BUILDING: _____ B. WING _____	07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASSIONATE COTTAGE II	1506 UPPER TRENTWOOD CIRCLE NE WILLMAR, MN 56201

(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: SL32777015-0 On July 11, 2022, through July 13, 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 ten residents, all of whom received services under the provider's Assisted Living license. An immediate correction order was identified on July 12, 2022, issued for SL32777015-0, tag identification 2310. On July 13, 2022, the immediacy of correction order 2310 was removed, however, non-compliance remained at level 3, widespread scope.	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 comply with Minnesota Food Code, Chapter 4626. This had the potential to affect all ten residents residing at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the additional documentation	0 480		

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0 480	Continued From page 2 included in the Food and Beverage Establishment Inspection Reports, dated July 11, 2022. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to establish and maintain an effective infection control program that complied with accepted health care, medical and nursing standards for infection control related to COVID-19. This had the potential to affect the licensee's ten current residents, staff and visitors. In addition, the licensee failed to ensure infection control standards were followed for three of three unlicensed personnel (ULP-E, ULP-F, ULP-C) during the service delivery of personal cares. 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	0 510		

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0 510	Continued From page 3 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 EMPLOYEE EYE PROTECTION Upon entrance to the facility on July 11, 2022, at approximately 10:05 a.m., the surveyor observed licensed assisted living director (LALD)-A, clinical nurse supervisor (CNS)-B, unlicensed personnel (ULP)-C, and ULP-D engaging with residents in the common area. LALD-A, CNS-B, ULP-C and ULP-D wore a medical-grade facemask, but no eye protection. On July 11, 2022, at approximately 11:05 a.m., when the surveyor questioned the lack of eye protection, CNS-B stated the COVID rate in their county was "low," therefore staff had not been required to wear eye protection. The surveyor and CNS-B looked at the Centers for Disease Control and Prevention (CDC) COVID Data Tracker, updated July 7, 2022, which revealed Kandiyohi County, Minnesota (MN) community transmission was "high." The Minnesota Department of Health (MDH) guidance titled, "COVID-19 PPE and Source Control Grids - for congregate care settings, by community transmission level", dated April 7, 2022, indicated during "substantial" or "high" levels of community transmission (based on the Centers for Disease Control and Prevention (CDC) online data tracking system), caregivers must wear a face mask (source control) and eye	0 510		

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0 510	Continued From page 4 protection while working with residents without suspected or confirmed SARS-CoV-2 infection. The licensee's Coronavirus Disease 2019 (COVID-19): Preventing and Controlling the Transmission of COVID-19 policy, revised June 13, 2022, indicated the licensee would follow the direction of federal and state agencies regarding screening for symptoms, and implementing a plan to mitigate the development and spread of this disease within the facilities. INFECTION CONTROL ULP-E On July 12, 2022, at approximately 10:17 a.m., the surveyor observed ULP-E prepare to give R1 an injection to prevent blood clots. ULP-E brought R1 into her bathroom and positioned her onto the closed toilet seat. ULP-E donned gloves, lifted R1's shirt to expose her lower abdomen, cleaned the site with an alcohol prep, and gave the injection under the skin. ULP-E removed the gloves, and without performing hand hygiene, touched R1's walker, the bathroom light switch, the door handle, and escorted R1 to the dining room table and assisted her to sit down while holding on to the back of the chair. When R1 was positioned in the chair, ULP-E walked into the laundry area and put the syringe into the sharp's container and washed his hands in the sink. On July 12, 2022, approximately 10:25 a.m., ULP-E confirmed he had not washed his hands after removing the soiled gloves, exiting R1's room and touching multiple surfaces. ULP-F On July 13, 2022, at approximately 8:20 a.m., the surveyor observed ULP-F assist R5 with toileting.	0 510		

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0 510	Continued From page 5 After R5 voided, ULP-F donned gloves and provided pericare with a washcloth. Without removing the gloves, ULP-F obtained R5's toothbrush and put toothpaste on the toothbrush. ULP-F stood beside R5 while she finished brushing her teeth and handed her a cup of water to rinse her mouth. ULP-F removed the gloves, and without washing her hands, ULP-F used the remote to change the channel for R5, touched pillows, and assisted R5 into her chair. Still without performing hand hygiene, ULP-E left R5's room, touched the door handle and walked to the laundry room area to wash her hands. On July 13, 2022, at 8:35 a.m., ULP-F confirmed she did not remove her soiled gloves after assisting R5 with toileting and did not wash her hands or perform hand hygiene after removing the gloves and before leaving R5's room. ULP-C On July 13, 2022, at approximately 9:00 a.m., ULP-C donned gloves and prepared to assist R4 to get out of bed and to get dressed. ULP-C helped R4 to sit up on the side of the bed, transferred R4 into the wheelchair, and wheeled into the bathroom. R4 stood and ULP-C removed the urine soaked brief, tossed it into the trash, and removed her gloves. Without performing hand hygiene, ULP-C gathered clothing for R4 from her closet. ULP-C donned another pair of gloves and applied skin cream to R4's face, put on socks and shoes, and then removed the gloves. Without performing hand hygiene, ULP-C donned clean gloves. ULP-C washed R4's back, arms, and chest, and removed her gloves. Without performing hand hygiene, ULP-C donned gloves, and assisted R4 to put on her shirt. R4 stood up, ULP-C cleaned her bottom with a washcloth, placed a clean brief and pulled up the	0 510		

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0 510	Continued From page 6	0 510		

brief and her pants. ULP-C reached to pull the wheelchair closer by the armrest, removed her gloves, and set up R4's toothbrush. R4 sat in the wheelchair in front of the sink and brushed her teeth. ULP-C pulled the garbage bag from the trash and tied it, put in a new bag, and donned gloves. ULP-C combed R4's hair, put on her earrings and necklace, and handed her some lipstick. With gloves still on, ULP-C picked up the garbage bag, opened the door into the hallway, and pushed R4 down the hallway to the dining room table for breakfast. ULP-C threw the trash bag into the laundry room area, removed her gloves, and washed her hands.

On July 13, 2022, at approximately 9:20 a.m., ULP-C confirmed that she changed her gloves several times while providing personal cares for R4; however, did not perform hand hygiene until she was finished with R4's cares and left her room.

On July 13, 2022, at approximately 9:40 a.m., CNS-B stated it was difficult for the ULPs to wash their hands in the residents' room due to the resident's personal items being around the sink, and paper towels were not available in the rooms because residents would flush them, and hand sanitizer was a safety concern for some residents.

The licensee's Standard (Universal) Precautions for Infection Control policy, dated August 1, 2021, indicated gloves should be worn when touching blood, body fluids, feces, non-intact skin, mucus membranes, or contaminated items. Gloves should be changed between tasks and procedures on the same resident after contact with material that may contain a high concentration of microorganisms. In addition,

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0 510	Continued From page 7 remove gloves promptly after use, and before touching non-contaminated items, environmental surfaces, self, or other residents, and wash hands after removing gloves. The licensee's Procedure for Using Gloves policy, dated August 1, 2021, directed to wash hands, apply gloves to both hands, complete task, dispose of used gloves in proper receptacle, and fresh hands. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
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	0 680		

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0 680	Continued From page 8 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 have a written emergency preparedness (EP) plan with all of the required content and failed to post an emergency preparedness plan prominently. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the initial tour on July 11, 2022, at approximately 12:05 p.m., the surveyor observed the facility's layout included one large building with one level, a main entrance, large open common area, kitchen, dining room, sunroom, staff offices and resident apartment on both ends. Although emergency exit diagrams were posted throughout the facility and in residents' apartments on the inside of their apartment door, there was no evidence of signage posted or information regarding the licensee's emergency plan.	0 680		

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0 680	Continued From page 9 On July 13, 2022, at approximately 11:35 a.m., the licensee's owner/licensed assisted living director (LALD)-G and LALD-A stated the EP plan, dated August 1, 2021, was located in a red binder in the nurse's office which they indicated was locked when staff were not in the office. The plan included a hazard & vulnerability summary, which identified fire and weather-related events, as probable events, and included rapid response guides for each of these identified events. In addition, the plan included policies and procedures that were included in the Emergency Preparedness Plan, including but not limited to evacuation, transfer agreements, loss of power, infectious disease outbreak, medical records, and communication plan; however, the EP Plan lacked the following content: - subsistence needs for staff and residents during emergency situations; and - development of policies/procedures to address the use of volunteers and other emergency staffing strategies, including the process/role for integration. On July 13, 2022, at approximately 12:25 p.m., owner/LALD-G and LALD-A stated they were involved in the development of the emergency preparedness plan, and verified the above contents were not included, as required. The licensee's Emergency Preparedness policy, dated August 1, 2021, indicated emergency plan highlights and evacuation routes were provided to all residents upon move-in, with copies provided to families when requested. In addition, the Disaster and Emergency Plan was posted prominently in a public area of the facility for easy access. The policy lacked direction for subsistence needs for staff and residents during	0 680		

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0 680	Continued From page 10 an emergency situation and the use of volunteers and other emergency staffing strategies. No further 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	0 810		

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0 810	Continued From page 11 evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements and failed to provide required employee and resident training on fire safety and evacuation. 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 July 14, 2022, at approximately 10:20 a.m. with Owner/Licensed Assisted Living Director (LALD)-G and Licensed Assisted Living Director (LALD)-A on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. 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, LALD-A stated the fire safety	0 810		

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0 810	Continued From page 12 and evacuation plan lacked these provisions. Record review of available documentation indicated that the licensee provided training annually only and did not provide employee training on the fire safety and evacuation plan twice per year after initial hire. During interview, LALD-A stated employees are trained annually, and that the licensee did not have a policy or documentation to state otherwise. 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 or similar emergency. Provided documentation had no polices or records of documented resident training. During interview, LALD-A stated that the licensee did not have a policy or documentation to show resident training had been offered or conducted. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (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. (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	01620		

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01620	Continued From page 13 and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment after a change of condition for one of one resident (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, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On July 11, 2022, at approximately 10:25 a.m.., during the entrance conference, clinical nurse supervisor (CNS)-B verified comprehensive assessments were completed upon admission, at day 14, every 90 days and with any significant	01620		

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01620	Continued From page 14 change in condition. R1's diagnoses included dementia, high blood pressure, anxiety and peripheral vascular disease. R1's Service Plan dated April 1, 2022, indicated R1 received services including medication management, ambulation/exercise, bathing, dressing, grooming, toileting, safety check, housekeeping and laundry. On July 12, 2022, at approximately 10:17 a.m., the surveyor observed R1 while unlicensed personnel (ULP)-E administered an injection into her abdomen. R1's Assessment As of Date, dated June 13, 2022, indicated R1 had hypertension, currently controlled with medication and had a pacemaker that was checked as scheduled through the clinic. The assessment included INR (international normalized ratio) (blood test that measures the time for the blood to clot) checks and warfarin (medication to prevent blood clots) had been discontinued due to bleeding of unknown source. R1 reportedly had dark stools and was hospitalized on March 25, 2022, due to low hemoglobin; however, doctors were unable to find the location of the bleed. R1 was started on iron and low dose aspirin and could no longer take blood thinners. R1's progress notes, dated June 27, 2022, at 4:36 p.m., indicated R1 had "not been herself" and had shown increased weakness, shortness of breath and decreased appetite the past few days, and had a history of internal bleeding in her digestive tract. The notes also indicated shortness of breath, weakness and mild chest	01620		

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01620	Continued From page 15 discomfort. CNS-B contacted R1's provider and R1 was scheduled to see the provider the next day with a plan for lab work. On June 29, 2022, at 8:35 a.m., R1's progress note indicated R1 had been experiencing a decline in status, and after a series of tests at her appointment, she was admitted to the intensive care unit (ICU) with multiple blood clots in both lungs and stress to the heart. R1 was started on intravenous (administration through the veins) heparin (to decrease blood clots). On July 5, 2022, at 9:08 a.m., CNS-B documented R1 had returned to the facility on July 2, 2022, with low dose Coumadin (same as warfarin) and Lovenox injections (to prevent blood clots) twice daily, with frequent INR and a follow up appointment on July 8, 2022. R1's record lacked a change of condition assessment following R1's illness and hospitalization. On July 13, 2022, at approximately 10:02 a.m., CNS-B verified R1 had a change in condition, did not have a change in condition assessment completed, but should have when R1 returned from the hospital; however, stated she was waiting until R1's July 8, 2022, appointment to include the outcome of that appointment. The licensee's Initial and On-going Nursing Assessment of Residents Under the Comprehensive Licensed Agency (licensee has an assisted living license), dated August 1, 2021, indicated the RN would complete a comprehensive nursing assessment of the resident's physical, mental, and cognitive needs as required, which included a change in resident condition. No further information was provided.	01620		

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01620	Continued From page 16 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01650 SS=D	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; (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 observation, interview and record	01650		

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01650	Continued From page 17	01650		

review, the licensee failed to ensure the service plan included the required content for one of two residents (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, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

R1's service plan lacked the following:
- a contingency plan that included:
  - 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.

On July 12, 2022, at approximately 10:17 a.m., the surveyor observed R1 while unlicensed personnel (ULP)-E administered an injection into her abdomen.

R1's Service Plan dated April 1, 2022, indicated R1 received services including medication management, ambulation/exercise, bathing, dressing, grooming, toileting, safety check, housekeeping and laundry. The service plan lacked the required content noted above.

On July 13, 2022, at approximately 10:02 a.m., clinical nurse supervisor (CNS)-B confirmed the service plan for R1 lacked the required content

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01650	Continued From page 18 noted above and stated the service plan was not printed in the correct format, therefore, the information above was not included. The licensee's Contents of Service Plans policy, dated August 1, 2021, indicated the service plan would identify the fees for services, the schedule, and methods of monitoring assessment of the resident, the schedule and methods of monitoring staff providing services, and the plan for contingency action that included what actions would be taken if the scheduled services cannot be provided. Also, the policy indicated the service plan would identify how the resident or the resident's responsible person could contact a representative of the licensee, the name and telephone number of the resident's contact person in case of an emergency including identification of and contact information for who has the authority to sign for the resident in an emergency, and the circumstances in which emergency medical services are not to be summoned. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01650		
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	01940		

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01940	Continued From page 19 individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of one resident (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, 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	01940		

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01940	Continued From page 20 situation has occurred only occasionally). Findings include: During the entrance conference on July 11, 2022, at approximately 10:25 a.m.., clinical nurse supervisor (CNS)-B stated the licensee provided treatment management services to residents, including compression stockings. R1's record lacked a treatment management plan to include the following required content: - procedures for notifying a registered nurse when a problem arose with treatments or therapy services. R1's Service Plan dated April 1, 2022, indicated R1 received services including medication management, ambulation/exercise, bathing, dressing, grooming, toileting, safety check, housekeeping, laundry and compression stockings. R1's prescriber orders, dated April 20, 2022, included compression stockings to be worn daily. R1's Individualized Treatment and Therapy Plan, printed July 13, 2022, directed staff to put compression stockings on each morning, and to remove compression stockings at night before bed, and to note effectiveness and condition of the stockings and the condition of the skin. The Plan also indicated the registered nurse (RN) would monitor for compliance with the compression stockings. The Plan lacked procedures for notifying the RN when a problem arose, as required. On July 13, 2022, at approximately 10:10 a.m., CNS-B verified R1's treatment management plan	01940		

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01940	Continued From page 21 lacked the above required content. The licensee's Initial and On-going Nursing Assessment of Residents Under the Comprehensive Licensed Agency (licensee held a current assisted living license), dated August 1, 2021, indicated the RN would complete a comprehensive nursing assessment of the resident's physical, mental, and cognitive needs as required, which included a list of the type of treatments, the frequency, and the level of assistance needed. The policy lacked direction regarding the required contents of the treatment plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
02310 SS=I	144G.91 Subd. 4 Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for one of one resident (R3) with a hospital bed with bedrails, and one of one resident (R1) with an assistive device. This practice resulted in a level three violation (a	02310	On July 13, 2022, the immediacy of correction order 2310 was removed, however, non-compliance remained at level 3, widespread scope.	

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02310	Continued From page 22 violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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). This practice resulted in an immediate order for correction on July 12, 2022. The findings include: HOSPITAL BED R3 On July 12, 2022, at approximately 9:27 a.m., the surveyor observed clinical nurse specialist (CNS)-B measure R3's hospital bed bilateral bedrails. Both bedrails were in the raised position. The openings between the bars for zone 1, measured 3 inches. The measurements between the mattress and the bedrail for zone 3, measured 0 inches. The measurements between the top of the rail to the head of bed for zone 6 measured 6 1/4 inches. The measurement from the mattress to the headboard for zone 7, measured 1.5 inches. CNS-B stated R3 used the bedrails to help her transfer in and out of bed and to reposition herself while in bed. R3's diagnoses included dementia, high blood pressure, depression and fall risk. R3's Service Plan, dated April 1, 2022, indicated R3 received services which included bathing assistance, dressing, grooming, mobility assistance, toileting, transfer assistance, turning and repositioning, medication administration,	02310		

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02310	Continued From page 23 safety checks three times per day, housekeeping and laundry. R3's Assessment As Of Date, dated May 6, 2022, indicated R3 used a hospital bed that was rented, and R3 was at high risk for injury with bedrail usage due to having Alzheimer's dementia and a lack of understanding with cognition. The assessment lacked interventions to mitigate the identified risk. Also included, R3 was at high risk for falls from the bed and with self-transferring. CNS-B documented she and R3's family spoke at length regarding the benefits and risks, and she had provided printed information in the resident's admission packet, and R3's family determined the benefits of bedrails outweighed the risk. The assessment lacked documentation of measurements to ensure the bedrails were consistent with the Food and Drug Administration (FDA) guidelines. ASSISTIVE DEVICE R1 On July 12, 2022, at approximately 9:45 a.m., the surveyor observed R1's bed to have a single vertical, metal, rectangle-shaped device, white in color, on the right side of her bed. The device was not affixed to the bed; however, was bolted to a wood board, approximately 3 feet by 3 feet and was slid under the mattress. A sticker attached to the wood board indicated the name of the assistive device manufacturer, phone number and instructions to install under the mattress. The device was approximately 3-4 inches wide and had a horizontal bar that divided the opening of the device, with the top opening measuring approximately 5 3/4 inches, and the bottom opening measuring approximately 13 inches. The device was less than two inches from the	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32777	A. BUILDING: _____ B. WING _____	07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASSIONATE COTTAGE II	1506 UPPER TRENTWOOD CIRCLE NE WILLMAR, MN 56201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 24 mattress. CNS-B stated R1 used the device prior to coming to the facility to get in and out of bed, therefore, R1's family wanted her to continue to be able to use it. R1's diagnoses included dementia and high blood pressure and indicated R1 used a wheeled walker due to unsteady gait. R1's Service Plan, dated April 1, 2022, indicated R1 received services including bathing, dressing, compression stockings, grooming, mobility assistance, safety checks three times daily, medication administration and toileting. R1's Assessment As Of Date, dated June 13, 2022, indicated R1's device was used to assist with transferring in and out of bed and repositioning while in bed. The assessment noted R1 was currently taking an antidepressant that could affect mental status related to the use of bedrails and indicated R1 was confused and was more unsteady because of her confusion. The assessment lacked interventions to mitigate the identified risk. CNS-B documented she sat with family/resident to review the benefits and risks for R1 when using the device, provided written information in the resident's admission packet, and indicated R1 and family were aware of the risks but felt the benefits outweighed the risks. R1's record lacked evidence of a bedrail assessment that ensured the device was safe for use and lacked documentation that the device was installed per manufacturer's guidelines. In addition, the assessment lacked evidence the licensee referred to the Consumer Product Safety Commission (CSPC) for the most up-to-date information related to portable bed side rail recall information.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32777	A. BUILDING: _____ B. WING _____	07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASSIONATE COTTAGE II	1506 UPPER TRENTWOOD CIRCLE NE WILLMAR, MN 56201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 25 On July 12, 2022, at approximately 10:50 a.m., CNS-B stated she was not aware that measurements needed to be included on the bedrail assessment, and stated she recently received new information from the provider group the licensee belonged to, with forms and policies that directed the requirements with bedrail usage; however, had not implemented this process. The licensee's Side Rail Safety Assessment policy, dated February 8, 2022, noted the RN would assess and evaluate what the resident's needs were and assess to determine if the resident could safely utilize the bedrail/device and determine if the bedrail/device met the FDA's 2006 recommended dimensional measurements to reduce entrapment, and would educate the resident, their representative and/or family members about the risks related to bedrails. The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment with hospital beds, 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. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs), indicated "licensees should refer to individual manufacturer's guidelines for appropriate installation, maintenance and use. In addition, licensees should refer to the Consumer Product	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32777	A. BUILDING: _____ B. WING _____	07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASSIONATE COTTAGE II	1506 UPPER TRENTWOOD CIRCLE NE WILLMAR, MN 56201

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02310	Continued From page 26 Safety Commission (CSPC) for the most up-to-date information related to portable bed side rail recall information." The FDA, "A Guide to Bed Safety" revised April 2010, included the 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 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." No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	02310		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors Subd. 8.Notice to visitors. (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the required	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32777	A. BUILDING: _____ B. WING _____	07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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03090	Continued From page 27	03090		

notice was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity. This had the potential to affect all ten current residents in the assisted living facility, staff and any visitors of the licensee.

This practice resulted in a level one violation (a violation that has not 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).

The findings include:

Upon entrance on July 11, 2022, at approximately 10:05 a.m., the surveyor observed outside the front entrance and just inside the front entrance of the assisted living facility. There was no required posting for notification of electronic monitoring devices.

During a tour of the facility on July 11, 2022, at approximately 12:05 p.m., licensed assisted living director (LALD)-A confirmed no posting was available at the main entrance related to the statutory language for electronic monitoring.

The licensee's Electronic Monitoring policy, dated January 1, 2020, indicated Compassionate Cottage shall post a sign at each entrance accessible to visitors that states, "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities."

No further information was provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32777	A. BUILDING: _____ B. WING _____	07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASSIONATE COTTAGE II	**1506 UPPER TRENTWOOD CIRCLE NE WILLMAR, MN 56201**

(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
03090	Continued From page 28 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

Minnesota Department of Health
Food, Pools & Lodging Services
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *07/11/22*
Time: 10:33:54
Report: 7930221100

Food and Beverage Establishment Inspection Report

Location:
Compassionate Cottage Ii
1506 Upper Trentwood Circle Ne
Willmar, MN56201
Kandiyohi County, 34

Establishment Info:
ID #: 0039389
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3202352775
ID #:

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

The following orders were issued during this inspection.

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

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

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

KITCHEN FRIDGE: RAW EGGS ABOVE LUNCH MEATS, FRUIT AND OPEN BEVERAGE PITCHERS. GARAGE FRIDGE: RAW EGGS ABOVE LETTUCE.

Corrected on Site

3-500B Microbial Control: hot and cold holding

3-501.16A2 ** Priority 1 **

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

KITCHEN FRIDGE: FOODS MEASURED 43-46 DEG F. (CHOCOLATE CREAM PIE, LUNCH MEAT, MILK, SLICED CUCUMBERS). ALL POTENTIALLY HAZARDOUS FOODS WERE DISCARDED. A REPAIR COMPANY WAS CALLED. DO NOT PLACE FOODS BACK IN THE FRIDGE UNTIL IT IS 41 DEG F OR BELOW.

Comply By: 07/11/22

3-500D Microbial Control: disposition of food

3-501.18A ** Priority 1 **

MN Rule 4626.0405A Discard all TCS food prepared in the establishment or opened commercially packaged food when the time exceeds 7 days from the preparation or opening date or if the container or package is not marked.

HAM LUNCH MEAT WAS DATED 7/1 IN THE KITCHEN FRIDGE. DISCARD.

Food and Beverage Establishment Inspection Report

Corrected on Site

4-900 Protecting Clean Items

4-904.13

MN Rule 4626.0975 Protect preset tableware from contamination by wrapping, covering or inverting. Remove exposed preset tableware that is unused when a customer is seated or clean and sanitize exposed preset tableware that is not removed when a customer is seated.

SILVERWARE ON THE DINING ROOM TABLE WAS SITTING ON TOP OF NAPKINS AND EXPOSED. COVER SILVERWARE OR WRAP WITH NAPKIN.

Corrected on Site

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 43-46 Degrees Fahrenheit - Location: KITCHEN FRIDGE: CHOCOLATE CREAM PIE / LUNCH MEAT / SLICED CUCUMBERS / MILK
Violation Issued: Yes

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: GARAGE FRIDGE: MILK
Violation Issued: No

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

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 7930221100 of 07/11/22.

Certified Food Protection Manager: Sharon Mason

Certification Number: FM108118 Expires: 09/29/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: Tina Remmele
Tina Remmele, R.S.
Environmental Health Specialist
St. Cloud District Office
320-223-7302
tina.remmele@state.mn.us

Report #: 7930221100

Food Establishment Inspection Report

Minnesota Department of Health
Food, Pools & Lodging Services
P.O. Box 64975
St. Paul, MN 55164-0975

No. of RF/PHI Categories Out	3	Date	07/11/22
No. of Repeat RF/PHI Categories Out	0	Time In	10:33:54
Legal Authority MN Rules Chapter 4626		Time Out	

	Address	City/State	Zip Code	Telephone
Compassionate Cottage Ii	1506 Upper Trentwood Circle Ne	Willmar, MN	56201	3202352775

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0039389		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	X	
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	X	
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	X	Utensils, equipment & linens: properly stored, dried, & handled	X	
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		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		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:** 07/11/22

Inspector (Signature) Tina Remmle