Electronically Delivered

April 25, 2025

Licensee
Prairie Senior Cottages of Willmar, LLC
1701 19th Avenue Southwest
Willmar, MN 56201

RE: Project Number(s) SL20738016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 4, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

§ 144G.20.

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

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

To submit a hearing request, please visit:

https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

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

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

If you have any questions, please contact me.

Sincerely,

Kelly Thorson

Kelly Thorson, Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.us
Telephone: 320-223-7336 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
	20738	A. BUILDING: _____ B. WING _____	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PSC OF WILLMAR LLC	1701 19TH AVENUE SW 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 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: SL20738016-0 On March 31, 2025, through April 3, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were sixteen (16) resident(s); all of whom were receiving services under the Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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 SUBDIVISION 1-3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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

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0 470	Continued From page 2 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on March 31, 2025, at 9:38 a.m., clinical nurse supervisor (CNS)-A and quality improvement (QI)-B stated the licensee was familiar with current minimum assisted living requirements. On March 31, 2025, at 10:28 a.m., QI-B provided licensee's Direct-Care Staffing Plan dated March 28, 2024, stated the licensee developed and implemented a written staffing plan, however, lacked documentation the staffing plan had been reviewed at least twice a year. QI-B stated the licensee's staffing plan is updated annually and was unaware of this requirement. The licensee's Staffing, Direct-Care Staffing Plan and Daily schedule policy reviewed on June 6, 2024, indicated the staffing plan will be evaluated for the appropriate staffing levels in the facility and revised as needed at a minimum of two times a year. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 470		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food	0 480		

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

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0 480	Continued From page 4 and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated March 31, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		

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0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services All assisted living facilities must offer to provide or make available 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 menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by: Based on observation, and interview, the licensee failed to have menus prepared at least one week in advance and made available to all residents. This had the potential to affect all sixteen residents who received services. 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 the residents). The findings include: On March 31, 2025, at 10:44 a.m., upon tour of	0 485		

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0 485	Continued From page 6 the facility led by licensed assisted living director in residence (ALDIR)-C; the surveyor observed the licensee lacked a prepared menu. ALDIR-C stated they do not prepare a menu at least a week in advanced and was unaware of this requirement. The licensee's menu planning policy dated June 9, 2023, indicated menus are made available to residents and guest at least one week in advance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 485		
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 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 7 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 post the emergency preparedness plan (EPP) in a prominent location, post an emergency exit diagram prominently and failed to update the facility missing person policy quarterly. This had the potential to affect all residents, staff and visitors at the assisted living with dementia care license. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the facility tour led by licensed assisted living director in residence (ALDIR)-C on March 31, 2025, at 10:44 a.m., the surveyor observed lack of signage posted for the EPP as well as licensee's emergency exit diagrams. On March 31, 2025, at 12:55 p.m. ALDIR-C stated they did not have signage posted as they were unaware of the requirements. ALDIR-C provided surveyor with the EPP that was located at the front entrance under a cabinet in a bin.	0 680		

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0 680	Continued From page 8 On March 31, 2025, at 1:00 p.m. the surveyor observed the licensee's Missing Resident policy dated June 13, 2023. On April 3, 2025, clinical nurse supervisor (CNS)-A; quality improvement (QI)-B; and ALDIR-C stated they were unaware of the requirements for quarterly review for licensee's missing person policy. The licensee's emergency The Plan Part II policy dated March 11, 2025, indicated the goal for the plan is to prepare to respond and recover form emergencies that would affect facility staff, residents, visitor and the community. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	0 680		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the requirements of the Minnesota State Fire Code. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 775		

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0 775	Continued From page 9 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). Findings include: On a facility tour on April 1, 2025, from 9:10 a.m. to 9:45 a.m., with licensed assisted living director in residency (LALDIR)-C, the surveyor made the following observations of non-compliance with the requirements of the Minnesota State Fire Code (MSFC) in Minnesota Rules Chapter 7511: EXIT DOOR LOCKING ARRANGEMENTS There was a delayed egress locking system installed on all exit doors leading to the exterior exit path. The delayed egress door locking system was not provided with a device capable of deactivating the delayed egress door hardware to the unlocked position from the nurse station or other approved location in order for occupants to exit in the event of an emergency. The delayed egress locking system is required to be provided with a switch or device located at the nurse station or other approved location to deactivate the delayed egress locked exit doors in order for building occupants to exit in the event of an emergency. During an interview at 9:45 a.m., LALDIR-C, stated the procedures required to operate and unlock the delayed egress door locking system were not included in the fire safety and evacuation plan. The procedures required to operate and unlock	0 775		

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0 775	Continued From page 10 the delayed egress locking system in order for occupants to exit in the event of an emergency are required to be included in the fire safety and evacuation plan employee procedures. These procedures are required in accordance with MSFC in Minnesota Rules Chapter 7511. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice	0 810		

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0 810	Continued From page 11 per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On April 01, 2025, at 10:20 a.m., licensed assisted living director in residency (LALDIR)-C provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. The FSEP (fire safety and evacuation plan) included standard employee procedures but failed to provide specific employee and resident actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The provided FSEP was a general guidance for fire response including	0 810		

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	20738	A. BUILDING: _____ B. WING _____	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PSC OF WILLMAR LLC	1701 19TH AVENUE SW WILLMAR, MN 56201

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0 810	Continued From page 12 responding to a fire alarm but did not provide specific employee and resident actions to take in the event of a fire or similar emergency geared to this facility. LALDIR-C stated that she understood the plans requirements and that she would work on getting this up to date. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01620 SS=F	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 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.	01620		

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01620	Continued From page 13 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed an ongoing resident reassessment that did not exceed 90 days as required for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a 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: R1 R1 was admitted on April 26, 2003, and began receiving assisted living with dementia care services. R1's record contained assessments dated December 22, 2024, and March 28, 2025, which indicated 96 days had lapsed between assessments. R2 R2 was admitted on October 26, 2022, and began receiving assisted living with dementia care services. R2's record contained assessments dated November 13, 2024, and February 13, 2025, which indicated 92 days had lapsed between assessments.	01620		

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01620	Continued From page 14 On April 4, 2025, at 9:06 a.m., clinical nurse supervisor (CNS)-A stated, "unsure what had occurred; there was an increase case load between the cottages where assessments were late." The licensee's Initial and On-Going Nursing Assessments of Residents policy dated June 6, 2023, read ongoing assessments would be performed by the RN and would not exceed 90 days from the last date of the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were labeled including the opened-on date for time sensitive medication for one of one resident (R4). 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	01890		

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01890	Continued From page 15 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on March 31, 2025, at 9:38 a.m., clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to residents at the facility. R4's signed prescribed orders dated December 4, 2024, read the following: -Ipratrop/Albuterol 0.5-3 milligrams (mg)/3 milliliters(ml) 0.5-3/3 ml/mg inhale one vial via nebulizer twice daily for dyspnea and cough. R4's March 2025 Med Admin Summary, indicated R4 received Ipratrop/Albuterol March 1, through March 31, 2025. On March 31, 2025, at 11:08 a.m., surveyor observed R4's Ipratrop/Albuterol foil pack opened and used. Medication lacked a label with the resident name, and no open date. CNS-A stated was unsure why R4's nebulizer medication was not labeled with resident name nor opened date indicated on the package. On March 31, 2025, at 11:13 a.m. surveyor observed an open vial of tuberculin solution in the medication refrigerator that lacked an open date on the vial. CNS-A stated the tuberculin solution is administered to residents upon admit and new employees. CNS-A stated that the medication should have a label with the open date indicated and was unsure why it didn't.	01890		

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01890	Continued From page 16 The licensee's Storage of Medications policy dated August 1, 2021, indicated medication must be kept in its original container bearing the original prescription label and legible information stating prescription number, name of drug, strength and quantity of drug, expiration date of time-dated drug. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property for the facility. This deficient practice had the ability to affect all staff, residents, and visitors.	02040		

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02040	Continued From page 17 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 April 1, 2025, at 10:43 a.m. licensed assisted living director in residency (LALDIR)-C on the hazard vulnerability assessment for the physical environment of the facility. Record review indicated that the licensee had performed a hazard vulnerability assessment for the environmental risks of this facility but did not include the mitigation factors on and around the property. During interview, LALDIR-C stated he understood the requirements of this policy. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of	02110		

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02110	Continued From page 18 person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living facility with dementia care (ALFDC) developed and implemented the required policies and procedure and provided to residents or the resident's legal and/or designated representative at the time of move-in or at the time they began receiving assisted living services for two of two residents (R1, R2).	02110		

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02110	Continued From page 19 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted on April 26, 2003, and began receiving assisted living with dementia care services. R1's record included a Service Plan Agreement signed April 26, 2023, indicating R1's services included assistance with dressing and grooming, bathing, transfer, ambulation, mobility, blood glucose, medication management and administration and behavior. R2 R2 was admitted on October 26, 2022, and began receiving assisted living with dementia care services. R2's record included a Service Plan Agreement signed February 14, 2025, indicating R2's services included assistance with dressing and grooming, bathing, transfer, ambulation, mobility, medication management and administration and behavior. R1 and R2's records lacked evidence of documentation for receipt of required policies and procedures to be provided at the time of resident move-in to the facility.	02110		

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02110	Continued From page 20 On March 31, 2025, at 9:38 a.m., upon entrance conference clinical nurse supervisor (CNS)-A and quality improvement (QI)-B provided the licensee's admission packet Resident And Family Handbook and stated the dementia policies and procedures were within the handbook. Surveyor reviewed the licensee's handbook that lacked the required ten (10) policies. On April 1, 2025, at 4:50 p.m., clinical nurse supervisor (CNS)-A and quality improvement (QI)-B provided the following policies: - life enrichment; - behavioral symptoms and interventions; - family support and engagement; - dementia training; - safekeeping of possessions; - transportation; - philosophy; and - wandering and egress prevention. The licensee lacked the following policy: - medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications. On March 3, 2025, at 9:11 a.m. CNS-A and QI-B stated they were not aware of the requirements of 144G.82, Subd.3. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02110		

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

Type: Full
Date: *03/31/25*
Time: 11:05:58
Report: 7930251074

Food and Beverage Establishment Inspection Report

Location:
Psc Of Willmar Llc
1701 19th Avenue Sw
Willmar, MN56201
Kandiyohi County, 34

Establishment Info:
ID #: 0037447
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3202356022
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.

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

CINDY MCGREGOR HAS TAKEN THE CLASS (5/3/24) BUT DID NOT APPLY FOR THE STATE CERTIFICATE. CINDY OR ANOTHER FULL TIME FOOD EMPLOYEE MUST RE-TAKE THE CLASS AND SUBMIT TEST RESULTS, FEE AND ONLINE APPLICATION WITHIN 6 MONTHS OF THE TEST DATE. INFO EMAILED.

Comply By: 04/30/25

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

REPAIR / REPLACE THE BROKEN SHELF IN THE UPRIGHT FREEZER IN SECONDARY KITCHEN. STAFF STATED A NEW SHELF / PARTS WERE ON ORDER.

Comply By: 04/30/25

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

LIKE STATED ABOVE AT THE HANDWASHING SINK IN THE MAIN KITCHEN. A SAMPLE SIGN WAS EMAILED WITH REPORT.

Comply By: 03/31/25

Type: Full
Date: *03/31/25*
Time: 11:05:58
Report: 7930251074
Psc Of Willmar Llc

Food and Beverage Establishment Inspection Report

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 38 Degrees Fahrenheit - Location: MILK--UPRIGHT COOLER 1 IN MAIN KITCHEN
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: LIQUID EGGS--UPRIGHT COOLER 2 IN MAIN KITCHEN
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 41 Degrees Fahrenheit - Location: COOKIE DOUGH--MAIN FRIDGE IN SECONDARY KITCHEN
Violation Issued: No

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

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 7930251074 of 03/31/25.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

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