Electronically Delivered

May 16, 2025

Licensee
McCornell Court
122 McCornell Avenue North
Parkers Prairie, MN 56361

RE: Project Number(s) SL30437016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 15, 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 . . ."

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

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Jessie Chenze

Jessie Chenze, Supervisor
State Evaluation Team
Email: Jessie.Chenze@state.mn.us
Telephone: 218-332-5175 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
	30437	A. BUILDING: _____ B. WING _____	04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCORNELL COURT	122 MCCORNELL AVE N PARKERS PRAIRIE, MN 56361

(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: SL30437016-0 On April 14, 2025, through April 15, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 15 residents; 15 receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 680 SS=C	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680		

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0 680	Continued From page 1 (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 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 interview and record review, the licensee failed to review the missing resident plan at least quarterly. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of	0 680		

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0 680	Continued From page 2 the residents). The findings include: On April 15, 2025, at 1:30 p.m., the surveyor reviewed the licensee's Emergency Preparedness Plan (EPP), last reviewed by the licensee on April 4, 2025. The missing resident policy was not reviewed quarterly. On March 15, 2025, at 1:59 p.m., licensed assisted living director (LALD)-A stated the missing resident policy was not reviewed quarterly. LALD-A was not aware the missing resident policy needed to be reviewed quarterly. The Missing Client policy dated December 26, 2024, did not indicate when the policy would be reviewed. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0110, Subp. 4, effective October 2022, the licensed assisted living director (LALD) and clinical nurse supervisor (CNS) must review the missing resident plan at least quarterly and document any changes to the plan. 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	0 810		

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0 810	Continued From page 3 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 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 and provide the required training and drills. 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	0 810		

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0 810	Continued From page 4 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 14, 2025, at 11:15 a.m., maintenance (M)-D and clinical nurse supervisor (CNS)-B provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. M-D and CNS-B stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. This facility lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. CNS-B stated that she understood the areas of their policy that were incomplete and would work	0 810		

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0 810	Continued From page 5 on bringing this into compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure background studies (BGS) were submitted and a clearance received in affiliation with the assisted living licensee's health facility identification (HFID) for ten out of nineteen employees (registered nurse (RN)-G, H, K, N), licensed practical nurse (LPN)-L), maintenance (M)-D, I), social services (SS-C), activities (A)-M, and dietary (D)-J). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01290		

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01290	Continued From page 6 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on April 14, 2025, at 9:45 a.m., clinical nurse supervisor (CNS)-B stated the licensee was aware of required contents of employee records. The licensee's NET Study 2.0 Roster Report printed April 14, 2025, for HFID 30437, indicated the following assisted living employees were not affiliated. However, had cleared background studies affiliated with the on-campus skilled nursing facility (SNF) HFID 444: RN-G was hired August 24, 2008, at the SNF, and had a background study clearance date of January 14, 2008. RN-H was hired October 3, 2023, at the SNF, and had a background study clearance date of October 3, 2023. RN-K was hired October 9, 2002, at the SNF, and had a background study clearance date of November 12, 2002. RN-N was hired June 13, 2018, at the SNF, and had a background study clearance date of June 13, 2018. LPN-L was hired February 21, 2024, at the SNF, and had a background study clearance date of	01290		

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01290	Continued From page 7 February 21, 2024. M-D was hired January 21, 2010, at the SNF, and had a background study clearance date of January 26, 2010. M-I was hired October 3, 3022, at the SNF, and had a background study clearance date of September 27, 2022. SS-C was hired December 30, 2022, at the SNF, and had a background study clearance date of June 22, 2023. A-M was hired September 12, 2022, at the SNF, and had a background study clearance date of August 25, 2022. D-J was hired August 16, 2022, at the SNF, and had a background study clearance date of August 16, 2022. On April 14, 2025, at 12:00 p.m., CNS-B stated the above SNF employees assist at random times in the assisted living facility. On April 14, 2025, at 12:15 p.m., HR-E stated HR-E was not aware the SNF staff that randomly assist in the assisted living needed affiliation with the assisted living HFID. HR-E stated these staff had background clearance for the SNF HFID. The licensee's Background Study policy dated January 18, 2024, indicated all individuals aged 13 and older in applicable roles must undergo a background study, including finger printing. Background studies must be updated when the individual changes their role or employer. No further information was provided.	01290		

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01290	Continued From page 8 TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01650 SS=F	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 9 review, the licensee failed to ensure the service plan included the required content for three of three residents (R1, R2, 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 resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on April 15, 2025, at 9:45 a.m., clinical nurse supervisor (CNS)-B stated the licensee was familiar with current minimum assisted living requirements. R1 R1's diagnoses included hypertension (HTN-high blood pressure) and heart failure. R1's service plan dated October 7, 2024, indicated services included medication administration, vital signs, oxygen reminders, and assistance with bathing, and laundry. On April 14, 2025, at 11:15 a.m., the surveyor observed unlicensed personnel (ULP)-P provide scheduled noon medication administration to R1. R2 R2's diagnoses included HTN and chronic kidney disease. R2's service plan dated June 4, 2024, indicated services included medication administration, vital	01650		

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01650	Continued From page 10 signs, and assistance with bathing and laundry. R4 R4's diagnoses included HTN, and major depressive disorder. R4's service plan dated March 11, 2025, indicated services included medication administration, vital signs and assistance with bathing On April 15, 2025, at 7:35 a.m., the surveyor observed unlicensed personnel (ULP)-O provide scheduled morning medication administration to R4. R1, R2 and R4's service plan did not include 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. On April 15, 2025, at 11:35 a.m., clinical nurse supervisor (CNS)-B stated R1, R2, and R4's service plan was lacking circumstances when medical services are not to be summoned. CNS-B stated this required content was not on the service plan form and must have missed this requirement when the form was developed. The licensee's 8.0 Contents of Service Plans policy dated December 26, 2024, indicated the service plan will include 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		

Minnesota Department of Health
Fergus Falls District
2312 College Way
Fergus Falls
218-332-5150

Type: Full
Date: *04/15/25*
Time: 11:20:00
Report: 1049251075

Food and Beverage Establishment Inspection Report

Location:
Mccornell Court
122 Mccornell Ave N
Parkers Prairie, MN56361
Otter Tail County, 56

Establishment Info:
ID #: 0037466
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2183384671
ID #:

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

No NEW orders were issued during this inspection.

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 40.5 Degrees Fahrenheit - Location: 2% Milk
Violation Issued: No

Process/Item: Hot Holding
Temperature: 149 Degrees Fahrenheit - Location: Roast Beef
Violation Issued: No

Process/Item: Hot Holding
Temperature: 144.5 Degrees Fahrenheit - Location: Mashed Potatoes
Violation Issued: No

Process/Item: Hot Holding
Temperature: 135.5 Degrees Fahrenheit - Location: Broccoli
Violation Issued: No

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

INSPECTOR MET WITH NURSE EVALUATOR AND ESTABLISHMENT REPRESENTATIVE.

ALL FOOD IS PREPARED AND COOKED AT THE NURSING HOME. THE FOOD IS BROUGHT OVER IN INSULATED FOOD CARRIERS. THE FOOD IS SERVED IMMEDIATELY UPON ARRIVAL.

ALL UTENSILS AND DISHES ARE WASHED AND SANITIZED AT THE NURSING HOME.

THE ASSISTED LIVING DOMESTIC KITCHEN CONSISTS OF WOOD CABINETS, TILE FLOORING, TEXTURED CEILING, AND PAINTED WALLS.

Things to Remember:

1. The Certified Food Manager should be routinely conducting self inspections to ensure that employees are following proper food handling practices.

2. Educate employees on the importance of reporting to management any illness they have or have had recently. Management should exclude any workers ill with vomiting or diarrhea from handling food, and they should keep an up to date employee illness log.

3. There should be a Person in Charge at the establishment during all hours of operation. This person should ensure that employees are practicing good hand washing procedures, including being knowledgeable about when hand washing should be done and how to properly wash hands.

4. Employees should use spatula, tongs, deli tissue, gloves, or some other approved means to prevent any direct bare hand contact with ready to eat foods.

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 1049251075 of 04/15/25.

Certified Food Protection Manager: NA

Certification Number: _____ Expires: / /

Signed: _____
Establishment Representative

Signed: *Stephanie Reynolds*

Stephanie Reynolds
Public Health Sanitarian
Fergus Falls
218-332-5179
stephanie.reynolds@state.mn.us