Electronically Delivered

December 11, 2023

Licensee
Fremont Village Senior Living
26369 2nd Street East
Zimmerman, MN 55398

RE: Project Number(s) SL38981015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license with dementia care.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial survey on November 8, 2023, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

The Department of Health 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. The Department of Health documents state correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care 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 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
Per 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 residents/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 correction 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 reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

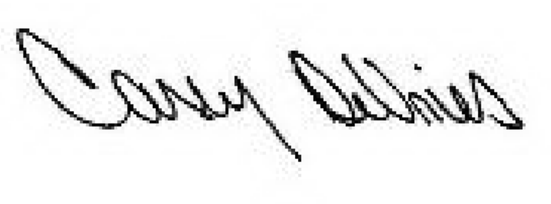
Please address your cover letter for reconsideration requests to:

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

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

If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 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
	38981	A. BUILDING: _____ B. WING _____	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREMONT VILLAGE SENIOR LIVING	26369 2ND STREET EAST ZIMMERMAN, MN 55398

(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 ******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: SL38981015-0 On October 6, 2023, through October 8, 2023, 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 71 active residents; 43 receiving services under the Provisional 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 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared 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) 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 the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated November 6, 2023, 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		
0 510 SS=D	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.	0 510		

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0 510	Continued From page 2 (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 gloving and hand hygiene for one out of four employees (unlicensed personnel (ULP)-B). 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: ULP-B was hired on October 17, 2022, to provide direct cares and services to residents. On October 6, 2023, from 10:48 a.m. to 10:56 a.m., during continuous observation, the surveyor observed ULP-B enter a resident's room within the memory care unit to assist with transferring the resident onto the toilet. The surveyor	0 510		

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0 510	Continued From page 3 observed ULP-B enter the resident's room and without completing hand hygiene put on clean gloves. The surveyor observed the ULP assist the resident with perineal cares at the toilet. After completing perineal cares, the surveyor observed ULP-B remove soiled gloves, and without performing hand hygiene or donning clean gloves, ULP-B assisted the resident with pulling up their pants and then assisted in transferring the resident back onto their wheelchair. ULP-B then exited the resident's room and was observed washing hands at sink in main living area of memory care unit. On October 6, 2023, at 10:56 a.m., ULP-B stated that they had received training on infection control and handwashing at time of hire and had also received ongoing training on infection control practices in online Relias (training software program) trainings as well as in-person trainings provided by the registered nurse (RN). On October 8, 2023, at 11:45 a.m., director of nursing (DON)-D stated that staff are trained to complete hand hygiene before and after administering medications as well as in between glove changes. Gloves should be worn while providing cares or administration of medications and treatments, and hand hygiene should be completed between glove changes as well as between residents. The licensees Hand Hygiene (Based upon the CDC Guideline Hand Hygiene in Healthcare Settings) policy dated July 2021 indicated that hand washing should be performed immediately before touching a patient, before performing aseptic techniques (indwelling device) or handling an invasive medical device, before moving from a soiled body site to a clean body site on same	0 510		

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0 510	Continued From page 4 resident/patient, after touching a resident/patient or the resident's/patient's immediate environment, after contact with blood, body fluids or contaminated surfaces, and immediately before putting on gloves and after glove removal. The Centers for Disease Control's (CDC), "CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings" dated November 29, 2022, under section 5a.1-2 read: 1.) Require healthcare personnel to perform hand hygiene in accordance with Centers for Disease Control and Prevention (CDC) recommendations. 2.) Use an alcohol-based hand rub or wash with soap and water for the following clinical indications: a.) Immediately before touching a patient; b.) Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices; c.) Before moving from work on a soiled body site to a clean body site on the same patient; d.) After touching a patient or the patient's immediate environment; e.) After contact with blood, body fluids or contaminated surfaces; and f.) Immediately after glove removal. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
01610 SS=F	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment.	01610		

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01610	Continued From page 5 (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan 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. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted an initial assessment using the uniform assessment tool on or before admission to the licensee for one of one resident (R5). 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: R5 was admitted to the licensee and began receiving assisted living services on March 6, 2023.	01610		

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01610	Continued From page 6 R5's Rental Agreement assisted living contract was signed on March 6, 2023. R5's signed service plan dated November 1, 2023, indicated R5 recieved assistance with medication assistance, bathing, laundry, toileting, and assistance with compression garments. R5's record contained admission assessment tools titled Level of Care Tool, BIMS Tool, and Medication/Treatment Individual Management Plan Tool, completed by a registered nurse (RN) on March 6, 2023. R5's record lacked evidence of a comprehensive nursing assessment that contained contents of the uniform assessment tool as required by Minnesota Administrative Rule 4659.0140 Subp. 2, prior to, or on the date of admission into the facility. R5's record contained an admission assessment containing the required elements of the uniform assessment tool, which was completed by a registered nurse 14 days after admission to the licensee on March 20, 2023. On November 7, 2023, at 1:20 p.m., director of nursing (DON)-D stated that it is the policy of the licensees management company and the practice within the facility to utilize the Level of Care Tool, BIMS Tool, and Medication/Treatment Individual Management Plan Tool, when completing admission assessments on residents, and that an admission assessment containing the required elements of uniform assessment tool was completed by an RN within 14 days of admission. The licensee's Minnesota Clinical Assessment Guide - AL and MC dated August 2022, indicated that the licensee would complete the Level of Care Tool, BIMs Tool, and Medication/Treatment	01610		

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01610	Continued From page 7 Management Tool pre-admission. The guide indicated that a Nursing assessment would be completed within 14 days of admission. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01610		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement and finalize a written	01640		

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01640	Continued From page 8 a service plan no later than 14 calendar days after the date services were first provided for one of four residents (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 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: R4 was admitted to the licensee and began receiving services on May 10, 2023. R4's diagnoses included memory loss, coronary artery disease, hypertension, and type 2 diabetes mellitus. R4's record included a Service Agreement form dated May 31, 2023, which indicated it was completed 21 days after the start of services, and showed that R4 received assistance with laundry, blood glucose monitoring, meal assist, ambulation - physical assist of one, dressing, grooming, bathing, toileting/incontinence care, medication administration, and transfer assist. On November 8, 2023, at 10:55 a.m., director of nursing (DON)-D stated, May 31, 2023, is the first service plan we have for her [R4]. I do not know why it was not completed within the 14 days, the nurse that signed her [R4] service agreement no longer works here so I am unsure as to what happened."	01640		

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01640	Continued From page 9 The licensee's Service Plan Guideline that was dated March 2015 and last revised September 2023, read, "The home care provider shall finalize a written service plan within 14 days after the initiation of home care services to a client [resident]." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure physician orders were transcribed accurately for one of four residents (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01760		

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01760	Continued From page 10 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: R5's Service Agreement, dated November 1, 2023, indicated R5's services included medication management, bathing, laundry, assistance with compression garments, and housekeeping services. R5's provider orders signed on November 2, 2023, included TEDS (brand of anti-embolism compression stockings) bilateral on in AM and off in PM one time a day for edema prescribed as a treatment. R5's electronic medication administration record (EMAR) included ACE Velcro wrap 4 inches on in the morning and off at bedtime. On November 7, 2023, at 7:30 a.m., the surveyor observed ULP-B apply TED hose and neoprene leg wraps to R5's lower extremities. On November 8, 2023, at 11:30 a.m., director of nursing (DON)-D verified that order for the application of TED hose was missing from the resident's EMAR and that it had been overlooked during order transcription. The licensee's Medications and Treatments policy dated March 2021, indicated that the RN is responsible for assuring that upon receipt of a medication and/or treatment order, whether new	01760		

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01760	Continued From page 11 or change of an order from an authorized prescriber, a licensed nurse must take action to implement the order within 24 hours. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must 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	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38981	A. BUILDING: _____ B. WING _____	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREMONT VILLAGE SENIOR LIVING	26369 2ND STREET EAST ZIMMERMAN, MN 55398

(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
01940	Continued From page 12 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 a treatment management plan to include all required content for one of four residents (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 potential to affect a large portion or all of the residents). The findings include: R4 was admitted to the licensee and began receiving services on May 10, 2023. R4's diagnoses included memory loss, coronary artery disease, hypertension, and type 2 diabetes mellitus. R4's record included a Service Agreement form dated May 31, 2023, which indicated it was completed 21 days after the start of services, and showed that R4 received assistance with laundry, blood glucose monitoring, meal assist, ambulation-physical assist of one, dressing, grooming, bathing, toileting/incontinence care, medication administration, and transfer assist. R4's medication Sheet dated October 1, 2023,	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38981	A. BUILDING: _____ B. WING _____	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREMONT VILLAGE SENIOR LIVING	26369 2ND STREET EAST ZIMMERMAN, MN 55398

(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
01940	Continued From page 13 through October 31, 2023, included TEDS (brand of anti-embolism compression stockings) on in the morning and off at bedtime (knee-hi) for Edema. R4's treatment plan completed within the 90-day assessment, dated August 10, 2023, lacked the following required content for TED stocking application: - resident specific instructions related to the treatments/therapy administration; - process for notifying an RN or appropriate licensed health professional when an issue or concern arises; and - resident specific requirements related to documentation of treatments/therapy received, verification that it was administered as prescribed and monitoring to prevent possible complications and/or adverse reactions. On November 8, 2023, at 11:23 a.m., director of nursing (DON)-D stated, "It is only on the MARs to put on and take off TEDS, there are no other instructions for the aides to see for what to do if there is a hole, or if or when to contact the nurse, I am going to put that on there right now. We will go through and fix this for everyone. We have it for blood glucose monitoring so not sure why this was missed." The licensee's Medications & Treatments policy dated August 14, 2014, indicated the individualized treatment plan would include the above content. No further information was provided TIME PERIOD FOR CORRECTION: Seven (7) days	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38981	A. BUILDING: _____ B. WING _____	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREMONT VILLAGE SENIOR LIVING	26369 2ND STREET EAST ZIMMERMAN, MN 55398

(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 14	02310		
02310 SS=F	144G.91 Subd. 4 (a) 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 provide care and services according to acceptable health care standards, medical, or nursing standards for two of two residents (R7 and R8) who utilized portable oxygen. 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: On November 7, 2023, at 12:56 p.m., the Minnesota Department of Health (MDH) engineer surveyor reported to the MDH nurse evaluation survyeor having observed unsecured oxygen cylinders during their facility tour. On November 7, 2023, at 1:12 p.m., the surveyor observed three small unsecured oxygen cylinders standing upright located behind the door of R7's	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38981	A. BUILDING: _____ B. WING _____	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREMONT VILLAGE SENIOR LIVING	26369 2ND STREET EAST ZIMMERMAN, MN 55398

(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 15 walk in closet. R7 stated, "I am well stocked, so stocked there isn't room for all of them [oxygen tanks]." On November 8, 2023, at 10:10 a.m., the surveyor observed three small unsecured oxygen cylinders standing upright located behind the door of R8's walk in closet. ADON-A secured the tanks and stated, "I think what happened is she [R8] is staying in the guest room while we redo her floors and the oxygen company just dropped them off on Monday, but since she is in the other room nobody saw it to correct it. We train the staff they always need to be secured. [R7], we don't manage her oxygen so we will need to probably reassess if she is appropriate to be managing her own oxygen." Minnesota Department of Health (MDH) Oxygen Cylinder Storage Requirements dated April 16, 2020, recommended cylinders be secured with chains or racks to prevent cylinders from falling over. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

DEPARTMENT OF HEALTH

Type: Full
Date: *11/06/23*
Time: 11:35:15
Report: 1037231287

Food and Beverage Establishment Inspection Report

Location:

Fremont Village Senior Living
26369 2nd Street East
Zimmerman, MN55398
Sherburne County, 71

Establishment Info:

ID #: 0042183
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/23

Operator:

Phone #:
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.

3-500D 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.

MILK CARTONS IN UPRIGHT LEGACY KITCHEN COOLER AND HEAVY CREAM IN THE WALK-IN COOLER WERE PAST DATE. DISCARDED FOOD ITEMS WHILE ON SITE.

Corrected on Site

4-300 Equipment Numbers and Capacities

4-302.13B ***** Priority 2 *****

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

AT THE TIME IF INSPECTION, THERE WAS NO TEMPERATURE INDICATOR FOR THE HOT WATER DISHWASHERS. PROVIDE AS DESCRIBED ABOVE FOR BOTH DISHWASHERS IN THE FACILITY.

Comply By: 11/27/23

Surface and Equipment Sanitizers

Acid: = 700 at Degrees Fahrenheit
Location: WIPING CLOTH BUCKET - KITCHEN
Violation Issued: No

Acid: = 700 at Degrees Fahrenheit
Location: SPRAY BOTTLE - DINING ENTRANCE
Violation Issued: No

Hot Water: = at 165.8 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Hot Water: = at 161.5 Degrees Fahrenheit
Location: DISHWASHER - LEGACY KITCHEN
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: MILK CARTON
Violation Issued: No

Process/Item: Hot Holding
Temperature: 197 Degrees Fahrenheit - Location: MUSHROOM SOUP
Violation Issued: No

Process/Item: Hot Holding
Temperature: 155 Degrees Fahrenheit - Location: SPAGHETTI NOODLES
Violation Issued: No

Process/Item: Hot Holding
Temperature: 182 Degrees Fahrenheit - Location: SPAGHETTI SAUCE
Violation Issued: No

Process/Item: Hot Holding
Temperature: 165 Degrees Fahrenheit - Location: BROCCOLI AND CAULIFLOWER
Violation Issued: No

Process/Item: Hot Holding
Temperature: 180 Degrees Fahrenheit - Location: BREADED CHICKEN PATTY
Violation Issued: No

Process/Item: Cold Holding
Temperature: 35 Degrees Fahrenheit - Location: PRECOOKED HAMBURGER PATTY
Violation Issued: No

Process/Item: Prep Cooler
Temperature: 35 Degrees Fahrenheit - Location: SLICED TOMATO
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 38 Degrees Fahrenheit - Location: MILK CARTON
Violation Issued: No

Process/Item: Hot Holding
Temperature: 154 Degrees Fahrenheit - Location: MUSHROOM SOUP - LEGACY KITCHEN
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: MILK CARTON - LEGACY KITCHEN
Violation Issued: No

Type: Full
Date: *11/06/23*
Time: 11:35:15
Report: 1037231287
Fremont Village Senior Living

Food and Beverage Establishment Inspection Report

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

DISCUSSED COOLING FOODS WITH MADONNA. MINIMAL FOODS ARE COOLED. ICE WANDS OR SHALLOW PANS ARE UTILIZED FOR COOLING FOODS. COOLING FACT SHEET AND COOLING LOG LEFT ON SITE.
MADONNA REQUESTED THE MODEL OF MY WATERPROOF, IRREVERSIBLE DISHWASHER THERMOMETER: DELTATRAK 11050.

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

I acknowledge receipt of the inspection report number 1037231287 of 11/06/23.

Certified Food Protection Manager: MADONNA P NOVOTHY

Certification Number: 55591 Expires: 08/29/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: Michelle L Hovanes

Michelle Hovanes
Public Health Sanitarian
St. Cloud
320-223-7307
michelle.hovanes@state.mn.us

Report #: 1037231287

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

No. of RF/PHI Categories Out	1
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 11/06/23
Time In 11:35:15
Time Out

Fremont Village Senior Living	Address: 26369 2nd Street East	City/State: Zimmerman, MN	Zip Code: 55398	Telephone
License/Permit #: 0042183	Permit Holder	Purpose of Inspection: Full	Est Type	Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

	Compliance Status					COS	R
Time/Temperature Control for Safety							
18	IN	OUT	N/A	(N/O)	Proper cooking time & temperature		
19	IN	OUT	N/A	(N/O)	Proper reheating procedures for hot holding		
20	IN	OUT	N/A	(N/O)	Proper cooling time & temperature		
21	(IN)	OUT	N/A	N/O	Proper hot holding temperatures		
22	(IN)	OUT	N/A		Proper cold holding temperatures		
23	IN	(OUT)	N/A	N/O	Proper date marking & disposition	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		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
Utensil Equipment and Vending				
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48	X	Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		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:** 11/07/23

Inspector (Signature) Michelle L Hoeman