Electronically Delivered

September 19, 2022

Administrator
Brooke Manor Inc
4878 Highway 31
Brookston, MN 55711

RE: Project Number(s) SL30235015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on September 8, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

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

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

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should be addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Jessica Chenze, Interim Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jessica.chenze@state.mn.us
Telephone: 218-332-5175 | Fax: 218-332-5196

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30235	A. BUILDING: _____ B. WING _____	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKE MANOR INC	4878 HIGHWAY 31 BROOKSTON, MN 55711

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0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#30235015 On, September 6, 2022, through September 8, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 10 residents, all of whom received services.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care/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 144A.474 subd. 11 (b) (1) (2) -or- 144G.31 subd. 1, 2 and 3.	

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0 480	Continued From page 1	0 480		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to 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 included document titled, Food	0 480		

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0 480	Continued From page 2 and Beverage Establishment Inspection Report dated September 6, 2022, for the specific Minnesota Food Code deficiencies. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of one resident (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a	0 630		

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0 630	Continued From page 3 limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's IAPP lacked specific measures to be taken to minimize the risk of abuse. R1's diagnoses included systemic inflammatory response syndrome (inflammatory state affecting the whole body) and dementia. R1's progress notes indicated the following: - August 6, 2022, at 1:36 p.m., the resident threw coffee across the table. - August 25, 2022, at 9:21 p.m., the resident tried to trip another resident by putting her foot out when they walked by her. - August 29, 2022, at 1:36 p.m., the resident after lunch threw her plate across the room. The resident was kicking, hitting, biting and spitting at staff. - August 31, 2022, at 1:49 p.m., the resident stole food from other resident's plates. - September 1, 2022, at 7:51 a.m., the resident got very angry during and after dinner. R1's Master Care Plan dated August 2, 2022, indicated R1 is at risk to be abused by others, and at risk to abuse other vulnerable adults. R1's Master Care Plan, which included the IAPP, did not include specific measures to be taken to minimize the risk of abuse. On September 7, 2022, at approximately 9:00 a.m., registered nurse (RN)-B confirmed R1's IAPP did not include specific measures to be taken to minimize the risk of abuse.	0 630		

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0 630	Continued From page 4 The licensee's Individualized Abuse Prevention Plan dated November 1, 2021, indicated the individual abuse prevention plan will include: specific measures to minimize the risk of abuse to that person and other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 630		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) 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 maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). The licensee failed to ensure a screening	0 660		

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0 660	Continued From page 5 for active TB (either a two-step tuberculin skin test (TST) or blood test) were completed and documented for one of two employees (unlicensed personnel (ULP)-C) with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee's TB Facility Risk Assessment, dated July 1, 2022, indicated the setting was a low risk for TB. ULP-C started employment on November 11, 2019, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On September 7, 2022, at approximately 8:10 a.m., the surveyor observed ULP-C administer R1's eye drops. ULP-C's employee record lacked evidence ULP-C had completed a TST prior to providing direct care to residents. On September 7, 2022, at approximately 11:00 a.m. licensed assisted living director (LALD)-A confirmed ULP-C's employee record lacked evidence ULP-C had completed a TST.	0 660		

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0 660	Continued From page 6 The licensee's Tuberculosis policy, dated November 1, 2021, indicated employees will complete a TST prior to providing direct care tor residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced	0 780		

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0 780	Continued From page 7 by: Based on observation and interview, the licensee failed to provide smoke alarms that complied with fire protection requirements. This had the potential to directly affect all residents and staff. 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: On September 6, 2022, between 1:20 p.m. and 2:10 p.m., survey staff toured the facility with the licensed assisted living director (LALD)-A. During the facility tour, survey staff observed that a smoke alarm was not installed in the basement. The LALD-A confirmed during the tour interview that the basement smoke alarm was missing. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.	0 800		

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0 800	Continued From page 8 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents and staff. 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: On September 6, 2022, between 1:20 p.m. and 2:10 p.m., survey staff toured the facility with the licensed assisted living director (LALD)-A. During the facility tour, survey staff observed the following: 1. A deadbolt lock that required a key to unlock was installed on the marked exit door in the basement. 2. The cover was missing on the light fixture above the shower stall in the shared resident bathroom. The LALD-A confirmed during the tour interview that a deadbolt lock was installed on the exit door and explained that the light cover had recently been broken and required repair. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		

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0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one 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 document review and interview, the licensee failed to provide the required plans,	0 810		

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0 810	Continued From page 10	0 810		

training, and drills for fire safety and evacuation. This had the potential to directly affect all residents and staff.

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:

On September 6, 2022, at approximately 2:10 p.m., the licensed assisted living director (LALD)-A provided documents for review. Documents were reviewed by survey staff on September 6, 2022, between 2:10 p.m. and 3:05 p.m.

1. The fire safety and evacuation plans within the Emergency Response Plan dated April 2022 did not include the identification of unique or unusual resident needs for movement or evacuation during a fire or similar emergency.
2. The licensee failed to provide documentation supporting the required employee training frequency. An orientation checklist for new employees was provided which included training on the fire alarm system. A copy of the notes from a staff meeting dated July 31, 2020, was provided which included information on fire drill procedures. The licensee failed to provide documentation supporting employee training on the fire safety and evacuation plans upon hire and at least twice per year thereafter.
3. The licensee failed to provide documentation supporting annual fire safety and evacuation training for residents. Documentation was requested by survey staff but not provided. The

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0 810	Continued From page 11 LALD-A explained that residents were trained but that it had not been documented. 4. The licensee failed to provide the required frequency for evacuation drills. Fire drill reports dated 06-12-2021 and 03-05-2022 were provided. The LALD-A was not able to locate additional documentation and explained that evacuation drills were completed quarterly. On September 6, 2022, at approximately 3:10 p.m., the LALD-A confirmed during an interview that the fire safety and evacuation plans required revision. They also confirmed that the training and drill frequency requirements were not met. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01420 SS=D	144G.62 Subd. 2 Delegation of assisted living services (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If an unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record.	01420		

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BROOKE MANOR INC	4878 HIGHWAY 31 BROOKSTON, MN 55711

(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
01420	Continued From page 12 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) conducted training and competency evaluations for one of two unlicensed personnel (ULP)-C who performed blood pressure monitoring. 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-C started employment on November 11, 2019, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On September 7, 2022, at approximately 9:20 a.m., the surveyor observed ULP-C perform blood pressure monitoring on R3 using an automatic digital blood pressure monitor. ULP-C's employee record indicated ULP-C had been trained on a manual blood pressure machine using a stethoscope on November 11, 2019. On September 7, 2022, at approximately 11:00 a.m., licensed assisted living director (LALD)-A confirmed the RN had not trained ULP-C and	01420		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30235	A. BUILDING: _____ B. WING _____	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKE MANOR INC	4878 HIGHWAY 31 BROOKSTON, MN 55711

(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
01420	Continued From page 13 demonstrated competency in the use of an automatic digital blood pressure monitor. The licensee's Delegated Task policy, dated November 1, 2021, indicated the registered nurse would conduct training and competency evaluations for delegated task prior to unlicensed personnel performing delegated tasks. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01420		
02410 SS=F	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or where clearly inadvisable or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during	02410		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30235	A. BUILDING: _____ B. WING _____	09/08/2022

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02410	Continued From page 14 toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure privacy was maintained during medication administration, resident COVID-19 screening, and blood pressure monitoring for three of five residents (R1, R3, R4) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On September 7, 2022, at approximately 8:10 a.m., the surveyor observed unlicensed personnel (ULP)-C administer erythromycin ointment (antibiotic) to R1's right eye. R1 was sitting in the living room with four other residents. On September 7, 2022, at approximately 9:17 a.m., the surveyor observed ULP-E perform oxygen saturation monitoring and temperature to R3 and R4, while R3 and R4 were sitting at the dining room table with another resident. At 9:20 a.m., the surveyor observed ULP-C perform blood pressure monitoring on R3, while R3 was sitting at the dining room table with two other residents.	02410		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30235	A. BUILDING: _____ B. WING _____	09/08/2022

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02410	Continued From page 15 On September 7, 2022, at approximately 10:00 a.m. licensed assisted living director (LALD)-A confirmed medication administration, temperature, oxygen saturation, and blood pressure monitoring should have been completed in a private area. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02410		

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

Type: Full
Date: *09/06/22*
Time: 10:10:00
Report: 7983221149

Food and Beverage Establishment Inspection Report

Location:
Brooke Manor Inc
4878 Highway 31
Brookston, MN55711
St. Louis County, 69

Establishment Info:
ID #: 0038796
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2184535262
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: Refrigerator/Freezer
Temperature: 40 Degrees Fahrenheit - Location: Hot dog in the refrigerator compartment of the GE refrigerator/freezer in the kitchen.
Violation Issued: No

Process/Item: Refrigerator/Freezer
Temperature: N/A Degrees Fahrenheit - Location: Food in the freezer compartment of the GE refrigerator/freezer in the kitchen was frozen solid.
Violation Issued: No

Process/Item: Refrigerator/Freezer
Temperature: 34 Degrees Fahrenheit - Location: Raw shell egg in the refrigerator compartment of the GE refrigerator/freezer in the storage area.
Violation Issued: No

Process/Item: Refrigerator/Freezer
Temperature: N/A Degrees Fahrenheit - Location: Food in the freezer compartment of the GE refrigerator/freezer in the storage area was frozen solid.
Violation Issued: No

Process/Item: Upright Freezer
Temperature: N/A Degrees Fahrenheit - Location: Food in the Frigidaire single-door upright freezer in the storage area was frozen solid.
Violation Issued: No

Process/Item: Chest Freezer
Temperature: N/A Degrees Fahrenheit - Location: Food in both Thompson chest freezers in the storage area was frozen solid.

Type: Full
Date: *09/06/22*
Time: 10:10:00
Report: 7983221149
Brooke Manor Inc

Food and Beverage Establishment Inspection Report

Violation Issued: No

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

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GENERAL COMMENTS:

1) Discussed excluding food employees ill with vomiting or diarrhea, eliminating bare hand contact with ready-to-eat food, and ensuring that in-house inspections of daily operations are conducted on a periodic basis to ensure that food safety policies and procedures are followed.

2) Meals are prepared the day of service. No cooling or hot holding. Leftovers are provided to staff.

3) Provided the fact sheet Highly Susceptible Population.

4) Inspected the well and subsurface sewage treatment system.

5) Well water is tested annually. The water sample for 2022 has not yet been submitted. Please submit the results for total coliform bacteria and nitrate nitrogen to your inspector when you receive them.

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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 7983221149 of 09/06/22.

Certified Food Protection Manager: Virginia Tuominen

Certification Number: FM70130 Expires: 10/04/22

Inspection report reviewed with person in charge and emailed.

Signed:_____ Signed: 7983

Virginia Tuominen
Owner

651-201-4500
health.foodlodging@state.mn.us