Electronically Delivered

October 31, 2025

Licensee
Ecumen Detroit Lakes the Cotta
1435 Madison Avenue
Detroit Lakes, MN 56501

RE: Project Number(s) SL25997016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 2, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

§ 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00

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

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

The correction order documentation should include the following:

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

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

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

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Jessie Chenze, Supervisor
State Evaluation Team
Email: Jessie.Chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

KKM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25997	A. BUILDING: _____ B. WING _____	10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECUMEN DETROIT LAKES THE COTTA	1435 MADISON AVENUE DETROIT LAKES, MN 56501

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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: SL25997016-0 On September 29, 2025, through October 2, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 19 residents; 19 receiving services under the Assisted Living Facility 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 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.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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

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0 480	Continued From page 2 existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated September 30, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee	0 480		

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0 480	Continued From page 3 within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure services were provided according to accepted health care, medical, or nursing standards in regard to infection control during resident cares for two of two employees (unlicensed personnel (ULP)-D, ULP-F). 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	0 510		

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0 510	Continued From page 4 a large portion or all of the residents). The findings include: During the entrance conference on September 29, 2025, at 9:10 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided assistance with ADLs (activities of daily living) to residents at the facility. On September 29, 2025, at 9:38 a.m. through 9:57 a.m., the surveyor toured the facility with CNS-B. The surveyor observed personal protective equipment (PPE), including N95 masks, gowns, gloves, goggles, face shields, and hand sanitizer), and a garbage can without a lid outside of suites (rooms) 54 and 67. CNS-B stated R5 and R6 inside suite 54, and R3 inside suite 67 were diagnosed with COVID-19 and ULPs were required to wear PPE when entering the suites. ULP-D ULP-D's Relias (on-line training platform) Transcript indicated ULP-D completed Infection Control Basics on March 19, 2024, and Infection Control, PPE, and TB (tuberculosis) on September 23, 2025, respectively. On September 29, 2025, at 12:51 p.m., the surveyor observed ULP-D administer R8's scheduled noon medications. The surveyor did not observe ULP-D complete hand hygiene before or after R8's medication administration. Immediately following the observation, the surveyor observed ULP-D put on a gown, gloves, N95 mask, goggles, and a face shield and entered R3's room. ULP-D exited R3's room after removing ULP-D's gown. ULP-D removed	0 510		

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0 510	Continued From page 5 ULP-D's gloves and N95 mask and threw them away in the garbage can (without a lid) located outside of R3's room. ULP-D removed ULP-D's face shield and goggles and placed them on top of the container where PPE was stored. The surveyor did not observe ULP-D disinfect ULP-D's face shield or goggles after exiting R3's room or remove the garbage containing PPE that was exposed to positive COVID-19 residents. On September 30, 2025, at 1:44 p.m., ULP-D stated ULP-D was trained to complete hand hygiene before and after glove removal. ULP-D further stated ULP-D was trained to remove the gown inside of positive COVID-19 resident room, place the gown in the garbage inside the resident's door, and all other PPE was to be removed outside of the resident room and placed into the garbage can outside the resident door. ULP-F On September 30, 2025, at 7:22 a.m., the surveyor observed ULP-F put on a gown, N95 mask, goggles, face shield, and gloves and entered R5 and R6's room and closed the door. At 7:43 a.m., ULP-F opened the door to get the sit to stand lift and then shut the door again. During the observation, the surveyor observed ULP-F's goggles and face shield placed on the top of ULP-F's head. At 7:54 a.m., ULP-F opened R5 and R6's door, the surveyor observed ULP-F had removed ULP-F's gown, goggles, and face shield inside R5 and R6's room. ULP-F proceeded to remove ULP-F's gloves and N95 mask and placed them into the garbage can (without a lid) located outside of R5 and R6's room. ULP-F disinfected ULP-F's goggles and face shield and placed them on the container where PPE was stored. The surveyor did not	0 510		

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0 510	Continued From page 6 observe ULP-F remove the garbage containing PPE that was exposed to positive COVID-19 residents. On September 30, 2025, at 12:50 p.m., ULP-F stated ULP-F was trained to remove the gown inside a resident room who was diagnosed with COVID-19. ULP-F further stated ULP-F was trained to remove the rest of the PPE outside of the resident room and place into the garbage can located outside of the resident room in the hallway. On October 1, 2025, at 8:51 a.m., CNS-B stated ULPs were trained to complete hand hygiene in between resident cares along with before and after glove removal upon hire and on an annual basis. CNS-B further stated all disposable PPE was required to be taken off just inside a COVID-19 resident room and placed in the garbage can located inside the resident room. After removal, ULPs were to disinfect their eyewear and goggles outside of the resident room using the disinfectant wipes provided by the licensee. CNS-B stated anytime a ULP was in a positive COVID-19 resident room the ULP was expected to have on all PPE until right before exit of the resident room. CNS-B further stated the garbage cans located outside positive COVID-19 resident rooms were for used disinfectant wipes only. The licensee's Hand Hygiene policy dated August 1, 2021, indicated hand washing shall be performed between client (resident) cares and whenever direct physical contact with a client takes place. The licensee's undated COVID-19 policy	0 510		

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0 510	Continued From page 7 indicated team members will wear appropriate PPE for enhanced respiratory precautions which include gown, gloves, eye protection/face shield, and N95 respirator. The policy did not address disposal of the PPE. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
01620 SS=D	144G.70 Subd. 2 (c-e) 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. (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. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days.	01620		

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01620	Continued From page 8 (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the registered nurse (RN) failed to conduct a comprehensive reassessment for one of two residents (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 an isolated scope (when one or a limited number of residents are affected or one or	01620		

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01620	Continued From page 9 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on September 29, 2025, at 9:13 a.m., clinical nurse supervisor (CNS)-B stated CNS-B completed preadmission, admission, 14-day, 90-day, and change of condition assessments, including change in services or hospitalization. R5's diagnoses included diabetes, Alzheimer's disease, and positive for Covid-19. R5's (licensee name) Home Care Service Plan dated September 21, 2025, indicated R5's services included medication administration, TEDS (compression stockings to reduce swelling in the legs), blood glucose monitoring, bathing, dressing, and vital sign monitoring. R5's Progress Notes dated September 22, 2025, indicated R5 had tested positive for Covid-19. On September 30, 2025, at 7:22 a.m., the surveyor observed unlicensed personnel (ULP)-F put on personal protective equipment (PPE) and enter R5's room to assist R5 with morning cares. R5's Medication Administration Record (MAR) dated September 2025, indicated effective September 22, 2025, and ending October 3, 2025, to check R5's vital signs three times daily. If vitals are outside normal parameters, notify nurse or triage. Normal ranges: Temperature: 97.0-99.0 degrees Fahrenheit (F), Pulse (heart rate) 60 to 100 beats per minute, respiratory rate 12 to 20 breaths per minute, blood pressure:	01620		

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01620	Continued From page 10 systolic 90 to 100 millimeters of mercury (mmHg)/ diastolic 60 to 80 mmHg, oxygen saturation 95 to 100 percent on room air, and for: Covid. From September 22, 2025, through September 30, 2025, respectively, one out of 24 opportunities R5's vital signs were documented on the MAR. R5's record included an AL (assisted living) assessment dated September 21, 2025 (one day prior to testing positive for Covid-19), which indicated 90-day assessment was the reason for the assessment. R5's record lacked a change of condition assessment and implementation of monitoring interventions after R5 was diagnosed positive for COVID-19 on September 22, 2025. On September 30, 2025, at 7:57 a.m., ULP-F stated ULPs were instructed to take vital signs for any positive Covid-19 residents for the first "couple" days after the resident tested positive for Covid-19. On October 1, 2025, at 12:53 p.m., CNS-B stated R5 was not assessed for a change of condition after testing positive for Covid-19. CNS-B further stated R5 was supposed to have vital signs monitored three times per day, however, was not sure why the vital signs documentation had an X documented and not the actual vital sign readings. CNS-B stated any resident who tested posted for Covid-19 was to receive vital sign monitoring three times per day for 10 days. The licensee's Initial and On-Going Nursing Assessment of Residents policy dated August 1, 2021, indicated nursing assessments are	01620		

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	25997	A. BUILDING: _____ B. WING _____	10/02/2025

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ECUMEN DETROIT LAKES THE COTTA	1435 MADISON AVENUE DETROIT LAKES, MN 56501

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01620	Continued From page 11 completed by a RN based upon the required assessment schedule and as needed based upon resident condition. The RN will reassess the resident if the resident has a change of condition. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
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 medications were administered per prescriber orders for one of five residents (R4) observed during medication administration. 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 12 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: During the entrance conference on September 29, 2025, at 9:10 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility. R4's diagnoses included hypertension (HTN-high blood pressure) and irritable bowel syndrome (IBS). R4's (licensee name) Home Care Service plan dated July 15, 2025, indicated R4's services included medication administration one to three times daily. R4's prescriber orders dated September 5, 2025, included an order for Questran (for IBS) four grams - give a half of pack (two grams) by mouth in four to eight ounces of water daily. In addition, may administer Questran two grams by mouth everyday PRN (as needed). R4's Medication Administration Record (MAR) dated September 2025, indicated R4 received Questran two grams (half pack) with four to eight ounces of water or juice every morning from September 6, 2025, through September 30, 2025, respectively. On September 30, 2025, at 6:54 a.m., the	01760		

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01760	Continued From page 13 surveyor observed unlicensed personnel (ULP)-D administer R4's scheduled morning medication. During the observation, the surveyor observed ULP-D compare R4's Questran four-gram packet to R4's MAR, placed the entire packet of Questran four grams into a plastic cup, and added approximately four ounces of water. ULP-D administered Questran four grams to R4, returned to the computer, and documented ULP-D administered R4 two grams of Questran. The surveyor did not observe ULP-D notify a supervisor of the medication error. On September 30, 2025, at 1:41 a.m., ULP-D stated R4 was administered the entire packet of Questran four grams instead of receiving half the packet of Questran two grams. On October 1, 2025, at 8:57 a.m., CNS-B stated if the resident's MAR included specific instructions about the mediation the ULP was expected to follow the instructions. On October 3, 2025, at 8:37 a.m., CNS-B emailed (electronic mail) the surveyor. The email indicated if a medication error occurred, the licensee would follow the medication error policy. In addition, ULPs were required to document confirmation after the medication is administered in the licensee's online resident record system following the six rights of medication administration. The licensee's Medication Error Reporting Policy dated August 2019, indicated all medication errors are reported to assure resident safety as well as for quality improvement purposes. In addition, all medication errors will be promptly reported.	01760		

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01760	Continued From page 14 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one refrigerator storing medications maintained an acceptable temperature and medications were stored according to manufacturer's recommended temperature. 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: During the entrance conference on September 29, 2025, at 9:10 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility.	01880		

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01880	Continued From page 15 On September 30, 2025, at 7:09 a.m., the surveyor observed the medication refrigerator, located in the locked medication and record room, with unlicensed personnel (ULP)-D. ULP-D stated the current temperature was 38 degrees Fahrenheit (F) to 40 degrees F, the medication refrigerator temperature was not assigned to be check on ULP-D's shift, and the medication refrigerator had a wireless thermometer attached to it. The medication refrigerator contained the following medications: -six unopened Lantus 100 units/milliliter (mL) - 3 mL insulin pens for R5; and -eight unopened Bisacodyl 10 milligram (mg) suppositories for R7. The licensee's Sensor History dated September 1, 2025, through October 1, 2025, indicated a daily sensor temperature reading for the medication refrigerator. The Sensor History chart indicated 14 out of 31 opportunities the medication refrigerator temperature was less than 36 degrees F. On September 30, 2025, at 9:02 a.m., licensed practical nurse (LPN)-C stated the medication refrigerator temperatures were monitored by the licensee's maintenance staff. On October 1, 2025, at 8:55 a.m., licensed assisted living director (LALD)-A stated the medication refrigerator had an electronic thermometer that measured the medication refrigerators temperature daily and was sent to the licensee's environmental services director and CNS-B. On October 1, 2025, at 10:31 a.m., CNS-B stated	01880		

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01880	Continued From page 16 CNS-B was not getting alerts of the medication refrigerator temperatures being out of the range of 36 degrees F to 46 degrees F. CNS-B further stated if the medication refrigerator was out of the 36 degrees F to 46 degrees F range, it would have been expected for the medication refrigerator temperature to be readjusted and a follow up medication refrigerator temperature to be recorded that was in the 36 degrees F to 46 degrees F range. The manufacturer's instructions for Lantus dated May 2019, indicated to store unopened Lantus in the refrigerator at 36 degrees F to 46 degrees F. Do not allow Lantus to freeze. The manufacturer's instructions for Bisacodyl Suppository dated November 21, 2022, indicated to store Bisacodyl Suppository at room temperature between 59 degrees F to 86 degrees F. The licensee's Storage of Medications policy dated August 1, 2021, indicated medications will be handled and stored per acceptable standards. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must	01960		

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01960	Continued From page 17 include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to document any follow up procedures for treatments provided to meet the resident's needs for one of two residents (R5) with treatments managed by the provider. 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: During the entrance conference on September 29, 2025, at 9:19 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided treatments and therapy to residents at the facility. R5's diagnoses included diabetes, Alzheimer's disease, and positive for Covid-19. R5's (licensee name) Home Care Service Plan dated September 21, 2025, indicated R5's services included blood glucose monitoring twice	01960		

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01960	Continued From page 18 per day. Notify nurse/triage If blood sugar below 70 or above 400. If blood sugar is above 520 call provider. R5's prescriber orders dated September 26, 2025, included an order for blood glucose monitoring two times per day. If blood sugar (glucose) reading is above 520 contact provider. R5's Medication Administration Record (MAR) dated September 2025, indicated R5 received blood glucose monitoring every morning and every night. On September 30, 2025, at 7:22 a.m., the surveyor observed unlicensed personnel (ULP)-F put on personal protective equipment (PPE) and enter R5's room to assist R5 with morning cares. R5's Blood Sugar dated September 1, 2025, through September 29, 2025, respectively, indicated blood glucose levels were complete twice per day. The following dates resulted in a blood glucose reading over 400: -September 12, 2025, at 10:12 p.m., blood glucose was 405; -September 15, 2025, at 8:52 p.m., blood glucose was 440; and -September 21, 2025, at 9:09 p.m., blood glucose was 481. R5's record lacked evidence the registered nurse (RN) was notified of the above noted blood glucose results greater than 400 milligrams (mg)/ deciliter (dL). On October 1, 2025, at 12:48 p.m., CNS-B stated CNS-B would have to review documentation to determine if an RN was notified for R5's blood	01960		

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01960	Continued From page 19 glucose readings higher than 400. CNS-B further stated ULPs were expected to contact the RN on call or the triage line for out of range blood glucose readings for R5 and a follow up note would be documented. On October 3, 2025, at 8:37 a.m., CNS-B emailed (electronic mail) the surveyor. The email indicated ULPs are expected to notify RNs if blood sugars are outside of the parameters of 70 mg/dL to 400 mg/dL. The RN would evaluate symptoms, determine if insulin needs to be held or given, and determine if resident should be further evaluated. This information (documentation from ULP and RN) is documented in Service Minder (licensee's online medical record system). The licensee's Individualized Medication, Treatment, and Therapy Management Plans policy dated August 1, 2021, indicated the treatment and therapy management plan will include 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 and/or therapy to prevent possible complications or adverse reactions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with	02320		

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02320	Continued From page 20 continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the steps of the medication administration process was followed for one of two employees (unlicensed personnel (ULP)-F) observed administering medications. 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: During the entrance conference on September 29, 2025, at 9:10 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility. R10's diagnoses included chronic obstructive pulmonary disease (COPD-difficult breathing). R10's (licensee name) Home Care Service Plan dated August 11, 2025, indicated R10's services included inhaler medication administration one time per day.	02320		

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02320	Continued From page 21 R10's prescriber orders dated September 5, 2025, included an order for Incruse Ellipta (for breathing) 62.5 micrograms (mcg)/actuation (act) inhale one puff a day for shortness of breath. Rinse mouth out with water after use. R10's Med Medication Administration Record (MAR) dated September 2025, indicated R10 was administered Incruse Ellipta 62.5 mcg/act inhale one puff every morning. Rinse mouth out with water after use. On September 30, 2025, at 8:49 a.m., the surveyor observed ULP-F provide scheduled morning medication administration for R10. ULP-F handed R10 the Incruse Ellipta inhaler, R10 inhaled one puff from the Incruse Ellipta inhaler, R10 handed the Incruse Ellipta inhaler back to ULP-F, and ULP-F administered R10's oral medications with water. The surveyor did not observe ULP-F offer R10 water to rinse and spit after inhalation of the Incruse Ellipta inhaler. On September 30, 2025, 12:52 p.m., ULP-F stated R10 does not like to rinse and spit after the Incruse Ellipta inhaler, however, ULP-F stated ULP-F should have offered water to R10 to rinse and spit. On October 1, 2025, at 8:57 a.m., CNS-B stated if the resident's MAR included instructions for the resident to rinse and spit after inhaler use, the ULPs were expected to offer water to rinse and spit each time that specific inhaler was administered to the resident. The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel	02320		

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02320	Continued From page 22 policy dated August 1, 2021, indicated the RN (registered nurse) can delegate administration of medications to ULPs if the RN has developed written, specific instruction for each client (resident) and the RN has documented that the ULP has been trained and have demonstrated competency to follow the procedures. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

Fergus Falls District Office
Minnesota Department of Health
2314 College Way
Fergus Falls , MN 56537
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Ecume Detroit Lakes The Cotta
1435 Madison Ave
Detroit Lakes, MN 56501
Becker County
Parcel:

Phone:

License Info

License: HFID 25997

Risk:
License:
Expires on:
CFPM:
CFPM #: ; Exp:

Inspection Info

Report Number: F1049251157
Inspection Type: Full - Single
Date: 9/30/2025 Time: 11:20 AM
Duration: minutes
Announced Inspection: Yes
Total Priority 1 Orders: 0
Total Priority 2 Orders: 1
Total Priority 3 Orders: 2
Delivery: Emailed

New Order: 3-300B Protection from Contamination: cross-contamination, eggs
3-302.12 *Priority Level: Priority 3 CFP#: 37*
MN Rule 4626.0240 Properly label all working containers holding food or food ingredients that are removed from original packages with the common name of the food. Label the food in English and any other languages used by employees who handle food.
COMMENT: IN THE DRY STORAGE AREA, BROWN SUGAR, CHEERIOS, AND RAISIN BRAN WERE BEING HELD IN BULK STORAGE CONTAINERS WITHOUT A LABEL STATING THE COMMON NAME OF THE FOOD. PIC LABELED ALL THREE(3) FOOD CONTAINERS DURING THE INSPECTION. VIOLATION WAS CORRECTED ON SITE.
Comply By: Complied On Site Originally Issued On: 9/30/2025

New Order: 4-900 Protecting Clean Items
4-904.11B *Priority Level: Priority 3 CFP#: 44*
MN Rule 4626.0965B Present clean knives, forks, and spoons that are not prewrapped in trays and holders so that only the handles are touched by employees or consumers.
COMMENT: IN THE DRY STORAGE AREA, THE PLASTIC SILVERWARE WAS NOT INVERTED IN THE HOLDER. DURING THE INSPECTION, PIC INVERTED THE PLASTIC SILVERWARE SO THAT THE HANDLES WERE POSITIONED UP IN THE HOLDERS.

THE SILVERWARE THAT CAME FROM CENTRAL KITCHEN WERE NOT INVERTED IN THE HOLDERS. DURING THE INSPECTION, THE PIC INVERTED THE SILVERWARE SO THAT THE HANDLES WERE POSITIONED UP IN THE HOLDERS.

VIOLATION WAS CORRECTED ON SITE.
Comply By: Complied On Site Originally Issued On: 9/30/2025

New Order: 6-300 Physical Facility Numbers and Capacities
6-301.11 *Priority Level: Priority 2 CFP#: 10*
MN Rule 4626.1440 Provide an adequate supply of hand soap at each handwashing sink or group of 2 adjacent handwashing sinks.
COMMENT: WHEN THE INSPECTOR ARRIVED, THE SOAP AT THE HANDWASHING SINK WAS OUT. PIC PROVIDED A REFILL OF THE SOAP DURING THE INSPECTION. VIOLATION WAS CORRECTED ON SITE.
Comply By: Complied On Site Originally Issued On: 9/30/2025

Food & Beverage General Comment

INSPECTOR MET WITH MDH NURSE EVALUATOR AND ESTABLISHMENT REPRESENTATIVE.

THE CENTRAL KITCHEN AT THE ECUMEN NURSING HOME PREPARES AND COOKS ALL OF THE FOOD FOR THE ASSISTED LIVING FACILITY.

THE ASSISTED LIVING FACILITY KITCHEN HAS ACOUSTIC CEILING TILES, LAMINATE FLOORING, LAMINATE COUNTERTOPS, AND WOOD CUPBOARDS.

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: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Fergus Falls District Office inspection report number F1049251157 from 9/30/2025

Stephanie Reynolds

Establishment Representative

Stephanie Reynolds,
Public Health Sanitarian 2
218-332-5179
stephanie.reynolds@state.mn.us

Fergus Falls District Office
Minnesota Department of Health
2314 College Way
Fergus Falls , MN 56537

Temperature Observations/Recordings

Establishment Info

Ecume Detroit Lakes The Cotta
Detroit Lakes
County/Group: Becker County

Inspection Info

Report Number: F1049251157
Inspection Type: Full
Date: 9/30/2025
Time: 11:20 AM

Food Temperature: Product/Item/Unit: 2% Milk**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 38.5 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Scalloped Potatoes and Ham**; Temperature Process:** Hot-Holding
Location: Steam Table at 184 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Cooked Carrots**; Temperature Process:** Hot-Holding
Location: Steam Table at 147 Degrees F.
Comment:
Violation Issued?: No

Fergus Falls District Office
Minnesota Department of Health
2314 College Way
Fergus Falls , MN 56537

Sanitizer Observations/Recordings

Establishment Info

Ecume Detroit Lakes The Cotta
Detroit Lakes
County/Group: Becker County

Inspection Info

Report Number: F1049251157
Inspection Type: Full
Date: 9/30/2025
Time: 11:20 AM

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** Wiping Cloth Bucket
Location: Kitchen **Equal To** 400 PPM
Comment:
Violation Issued?: No